NEW JERSEY STATE CANCER REGISTRY MANUAL

Abstracting and Coding Instructions for Health Care Facilities

2005

New Jersey State Cancer Registry
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National Cancer Institute The SEER Program and Stage Manual 2004, Fourth Edition
American College of Surgeons Facility Oncology Registry Data Standards Revised For 2004
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INTRODUCTION TO THE NEW JERSEY STATE CANCER REGISTRY

The New Jersey State Cancer Registry (NJSCR) is a population-based registry and includes all cancer cases diagnosed in New Jersey residents since October 1, 1978. The NJSCR serves the entire State of New Jersey, which includes a population of approximately 8.4 million people.

The purpose of the NJSCR is to track cancer in New Jersey in an effort to promote the following activities: scientific research; public and professional education programs; planning and implementation of cancer control and prevention activities. The NJSCR strives to improve the quality and enhance the usefulness of its data.

The NJSCR was established by legislation (NJSA 26:2-104 et.seq.) in 1977 in response to concern that New Jersey was suffering from the highest cancer incidence and mortality rates in the country. New Jersey regulations require the reporting of all newly-diagnosed cancer cases to the Registry within six months of diagnosis. All primary malignant and in situ neoplasms are reportable to the NJSCR, except in situ and localized basal cell and squamous cell carcinomas of the skin and carcinoma in situ of the cervix (since 1995). Benign and borderline intracranial and Central Nervous System tumors are reportable if diagnosed January 1, 2004 and later. Hospitals, physicians, dentists and independent laboratories also file reports with the NJSCR. In addition, reporting agreements are maintained with neighboring states so that New Jersey residents diagnosed in facilities out of state are identified.

The information collected by the NJSCR includes the following: demographic characteristics of the patient, medical information on each cancer such as primary site, histologic type, collaborative stage and treatment information. The vital status of each patient is followed annually until death. The cause of death is also incorporated into the data set if the information is available.

In February 2001, the NJSCR became a SEER (Surveillance, Epidemiology, and End Results) Registry. The SEER Program of the National Cancer Institute is the most authoritative source of information on cancer incidence and survival in the United States. Geographic areas selected for inclusion in the SEER Program is based on the Registries ability to operate and maintain a high-quality population-based cancer reporting system and for their epidemiologically significant population subgroups. The SEER Program currently collects and publishes cancer incidence and survival data from 14 population-based cancer registries and three supplemental registries covering approximately 26 percent of the US population. Information on more than 3 million in situ and invasive cancer cases is included in the SEER database, and approximately 170,000 new cases are added each year within the SEER coverage areas.

The NJSCR participates in the National Program of Cancer Registries (NPCR), established by the Centers for Disease Control (CDC) in 1992 by the Federal Cancer Registries Amendment Act (Public Law 102-515). NPCR promotes statewide, population-based registries to collect uniform data elements in a standardized format. The NJSCR is also a member of the North American Association of Central Cancer Registries (NAACCR). The North American Association of Central Cancer Registries, Inc. (NAACCR, Inc.), is a professional organization that develops and promotes uniform data standards for cancer registration; provides education and training; certifies population-based registries; and publishes data from central cancer registries.

Confidentiality

The New Jersey Cancer Registry Statute N.J.S.A.26:2-107 stipulates that reports of individual patients made to the NJSCR are held in the strictest confidence. Reports made pursuant to this act are used only by the State Department of Health and Senior Services and such other agencies as designated by the Commissioner of Health. N.J.S.A.26:2-108 stipulates that no individual or organization providing information to the State Department of Health in accordance with this act shall be held liable for divulging confidential information. Please note: reporting information about cases of cancer in accordance with the NJSCR authorizing statute and regulations *is permitted* by the Health Insurance Portability and Accountability Act. The privacy rule contains a specific provision authorizing covered entities to disclose protected health information as required by law. Public Health reporting under the authority of State law is specifically exempted from the Privacy Rule regulations 45CFR154.512(b)(I)(i). A copy of the Cancer Reporting Statute, Regulations and Reportable List can be referenced in Appendix E of this manual.

General Requirements for Reporting to the New Jersey State Cancer Registry

The New Jersey State Cancer Registry Manual 2004 contains coding instructions for all cases diagnosed January 1, 2004 and later. Documentation and codes for historical items can be found in The New Jersey State Cancer Registry Manual 2001.

What cancer should be reported to the NJSCR?

Benign and **borderline** primary **intracranial** and **CNS** tumors with a behavior code of /0 or /1 in ICD-O-3 are collected effective with cases diagnosed 1/1/2004 and later). See Appendix G for specific sites.

The following are **exclusions**:

8000-8004	Neoplasms, malignant NOS of the skin (C44.0-C44.9)
8010-8045	Epithelial carcinomas of the skin (C44.0-C44.9) unless regional or distant spread
8050-8082	Papillary and squamous cell carcinomas of the skin (C44.0-C44.9) unless regional or distant spread
8090-8110	Basal cell carcinoma of the skin (C44.0-C44.9)

Note: The above lesions are reportable for skin of the genital sites: vagina, clitoris, vulva, prepuce, penis, and scrotum (sites C52.9, C5.10-C51.9, C60.0, C60.9, C63.2).
Carcinoma in situ (any/2) and CIN III of the cervix (C5.30-C53.9) (cases diagnosed after April 1, 1995)

Prostatic intraepithelial neoplasia (PIN III) of the prostate (C619) (Collection stopped effective with cases diagnosed 1/1/2001 and later)

A case *must* be reported to the NJSCR if it is **diagnosed on or after October 1, 1978**.

All cancer patients diagnosed or treated in the **inpatient** or **outpatient department**, **emergency room, clinic** or **ambulatory care centers** must be reported including patients receiving transient care.

New Jersey residents and non-residents must be reported including residents of foreign countries.

Cases diagnosed at **autopsy** must be reported and patients dead on arrival (DOA) with a cancer diagnosis must be reported.

Patients diagnosed elsewhere and admitted for additional work-up and/ or treatment, cancer- directed or non cancer-directed must be reported.

Patients with a **clinical diagnosis** of cancer which was based on clinical judgement only must be reported.

Patients with a ***history of cancer with active disease*** must be reported.

If more than one primary cancer is diagnosed in a patient, **a separate report must be submitted for each primary**.

Consult-only cases are reportable. A consult may be done to confirm a diagnosis or treatment plan.

Private outpatient specimens are reportable. Generally, these specimens are submitted from a physician's office to be read by the hospital pathologist and the patient is not registered as an inpatient or outpatient at the hospital.

When the distinction between a free-standing facility and hospital-based department cannot be made such as a radiation therapy group practice versus a hospital unit, the ownership of the medical record should be used to determine who is responsible for reporting the case.

Ambiguous terms that must be reported include the following: **apparent(ly), appears, appears to**, **comparable with, malignant appearing, compatible with, consistent with, most likely, probable, suspected, suspicious, presumed, favor(s), typical of.**

Slide reviews are ***encouraged*** to be reported but are not required. Slide review cases are slides that have been sent to your hospital's pathologist for an opinion. Please do not confuse these with private outpatient or consult-only cases.

Certain borderline conditions are reportable. Refer to the reportable list in Appendix E for a list of these conditions.

When to Report to the New Jersey State Cancer Registry?

All cases of cancer and other specified tumors and precancerous diseases must be reported to the NJSCR within six months of diagnosis.

A health care facility that fails to report cases of cancer electronically, as required by regulation, within six months of the confirmed diagnosis shall be liable to pay a penalty as stated in N.J.S.A. 26:2-106 (Reference Appendix E for the Statute, Regulations and Reportable List).

How to Report to the New Jersey State Cancer Registry?

A cancer registry abstract must be completed for each newly-diagnosed case of cancer. A separate abstract must be completed for each primary. All abstracts from health care facilities must be submitted electronically

in NAACCR format Version 10 and in 2006 NAACCR format Version 11. All cases must be submitted electronically to the NJSCR via e-mail with either attached encrypted file or with an e-mail link to a secure encrypted e-mail server. Detailed instructions can be found in Appendix I.

Who Reports to the New Jersey State Cancer Registry?

Health care facilities, physicians, dentists, independent clinical laboratories that diagnose or provide treatment for cancer patients should report cancer cases to the NJSCR. All abstracting work performed by a health care facility which diagnoses or treats 100 or more cases per year must be performed by a certified tumor registrar who is certified by the National Cancer Registrars Association.

Methods of Reporting Changes, Updates, Deletions and Follow-ups to the NJSCR

Changes, deletions or updates to cases must be submitted in *paper format*. A printed copy of the hospital abstract highlighting the fields that have been changed, deleted and/or updated must be submitted via mail to the above referenced address or faxed to (609) 588-3638. It is important that you notify the NJSCR of any changes in your data base so that the NJSCR can maintain an up-to-date registry.

Methods to Receive Follow-up Information from NJSCR

The NJSCR can provide hospitals with vital status and dates of last follow-up on cases submitted by their own facilities. Hospitals interested in receiving this information should contact the NJSCR for further instructions regarding compression software and required passwords to ensure confidentiality in the transmission of this data.

NJSCR Guidelines for the Submission of Text Information

The New Jersey State Cancer Registry (NJSCR) requires the submission of text information to validate coded data items. Text is used for quality control purposes to justify codes for various data items. Text is also used to identify errors, to determine multiple primaries and to resolve discrepancies in data submitted on the same patient by multiple facilities.

All cancer registry software must include specific fields, which have been designed to record text information. These fields are transmitted to the NJSCR along with the other required data fields when you make your monthly electronic submission. Please refer to the table in Appendix C for the maximum number of characters per field. Please refer to Appendix F for a list of acceptable abbreviations. Recording text information should include but not be limited to the following:

- Record text to support primary site, laterality, histology, grade, collaborative stage, and treatment codes.
- Record text to justify any unusual information about the case which could result in potential questions, e.g. record text to support unusual site/histology combinations, such as age/site combinations, gender/site combinations.
- Record text to clarify modifications or dates on the abstract.
- If limited information is available in the medical record about a case, utilize the text field to state that limited information was available in the medical record.

Case Finding

Case finding is the system used to identify patients with reportable neoplasms. Case finding involves thorough, systematic monitoring of records maintained by various departments throughout the hospital. Multiple sources must be used to ensure complete reporting of all cases.

Case finding sources include:

Admission and discharge documents
Disease indices
Surgery schedules/ logs
Pathology and Cytology reports
Hematology reports
Autopsy reports
Outpatient medical records/logs
Nuclear medicine documents
Radiation oncology logs
Medical oncology logs

Screening List of ICD-9-CM Codes for Case Finding

Certain ICD-9-CM***** codes are used by medical records departments for discharge diagnoses to identify cases of neoplasms that are reportable. Case finding procedures should include the review of medical records coded with the following ICD-9-CM:

ICD-9-CM Codes:

042.2	**AIDS with specified malignant neoplasms**
140.0-208.9	**Malignant neoplasms (primary and secondary)**
225.0	**Benign neoplasm of brain**
225.1	**Benign neoplasm of cranial nerves**
225.2	**Benign neoplasm of cerebral meninges; cerebral meningioma**
225.3	**Benign neoplasm of spinal cord, cauda equina**
225.4	**Benign neoplasm of spinal meninges; spinal meningioma**
225.8	**Benign neoplasm of other specified sites of nervous system**
225.9	**Benign neoplasm of nervous system, part unspecified**
227.3	**Benign neoplasm of pituitary, craniopharyngeal duct, craniobuccal pouch, hypophysis, Rathke's pouch, sella turcica**
227.4	**Benign neoplasm of pineal gland, pineal body**
230.0-234.9	**Carcinoma in situ**
235.0-238.9	**Neoplasms of uncertain behavior includes:** **Pituitary gland and craniopharyngeal duct** **Pineal gland** **Brain and spinal cord** **Meninges; NOS, cerebral, spinal** **Neurofibromatosis, Unspecified von Recklinghausen's Disease** **Neurofibromatosis, Type One von Recklinghausen's Disease** **Neurofibromatosis, Type Two von Recklinghausen's Disease** **Other and unspecified parts of nervous system, cranial nerves** **Polycythemia vera (9950/3)** **Solitary plasmacytoma (9731/3)**

	Extramedullary plasmacytoma (9734/3) **Chronic myeloproliferative disease (9960/3)** **Myelosclerosis with myeloid metaplasia (9961/3)** **Essential thrombocythemia (9962/3)** **Refractory cytopenia with multilineage dysplasia (9985/3)** **Myelodysplastic syndrome with 5q- syndrome (9986/3)** **Therapy-related myelodysplastic syndrome (9987/3)**
239.0-239.9	**Neoplasms of unspecified behavior**
273.2	**Heavy chain disease (Alpha, Gamma, and Franklin's disease)**
273.3	**Waldenstroms macroglobulinemia**
273.9	**Unspecified disorder of plasma protein metabolism**
284.9	**Refractory anemia (9980/3)**
285.0	**Refractory anemia with ringed sideroblasts (9982/3)**
285.0	**Refractory anemia with excess blasts (9983/3)**
285.0	**Refractory anemia with excess blasts in transformation (9984/3)**
288.3	**Hypereosinophilic syndrome (9964/3)**
289.8	**Acute myelofibrosis (9932/3)**
V07.3	**Other prophylactic chemotherapy (screen carefully for miscoded malignancies)**
V10.0-V10.9	**Personal history of malignancy (review these for recurrences, subsequent primaries, and/or subsequent treatment)**
V58.0	**Radiotherapy session**
V58.1	**Admission for chemotherapy**
V66.1	**Convalescence following chemotherapy**
V66.2	**Convalescence following chemotherapy**
V67.1	**Follow-up exam following radiotherapy**
V67.2	**Follow-up exam following chemotherapy**
V71.1	**Observation for suspected malignant neoplasm**
V76.0- V76.9	**Special screening for malignant neoplasms**

*** International Classification of Disease, 9th Revision, Clinical Modification (4th ed., October 1991)**

Type of Reporting Source

1 Hospital Inpatient/Outpatient or Clinic
3 Laboratory-Only (Hospital or Private)
4 Physician's office/Private Medical Practitioner (LMD)
5 Nursing/Convalescent Home/Hospice
6 Autopsy-Only
7 Death Certificate-Only

Use Code 6, Autopsy-only, when the cancer was not diagnosed prior to the patient's death.
Code 7 is only assigned by the NJSCR and never by the facility.

Class of Case

The NJSCR requires the submission of analytic and non-analytic cases. The following defines analytic (0,1,2 and 6) and non-analytic cases (3,4,5,8 and 9).

Class 0 cases are diagnosed at the reporting institution and are treated elsewhere. Cases include:

- Patients who choose to be treated elsewhere.
- Patients who are referred elsewhere for treatment.

Class 1 cases are diagnosed at the reporting institution. They also fulfill one of the following treatment situations:

- Patient received all or part of his or her first-course of treatment at the reporting institution.
- Patient refused any therapy.
- Patient diagnosed at the reporting institution whose treatment plan is either to treat or watchful waiting.
- Patient was untreatable because of age, advanced disease, or other medical conditions or who were given palliative care.
- Specific therapy was recommended but not received at the reporting institution and it is unknown if therapy was ever administered.
- It is unknown if therapy was recommended or administered.
- Patient diagnosed at the reporting institution prior to the registry's reference date, all or part of first-course of treatment received at the reporting institution after the registry's reference date.
- Patient first diagnosed and had staging workup at the reporting institution and all or part of the first-course of treatment was received in a staff physician's office.
- Patient diagnosed in a staff physician's office and then treated at the reporting institution.
- Patient diagnosed and treatment plan developed and documented at the reporting institution. Therapy was delivered elsewhere in accordance with the treatment plan.

Class 2 cases are diagnosed elsewhere. They also fulfill one of the following treatment situations:

- The reporting institution administered part or all of the first-course of treatment.
- The reporting institution provided palliative care in lieu of first-course of treatment, or as part of first-course of treatment.

Class 3 cases are patients who were diagnosed and received all of their first-course of treatment elsewhere. They are then seen at the reporting institution for additional therapy or management and have active disease. This class of case includes:

- No information is available on his or her first-course of treatment. Patient is now treated or managed at the reporting institution.
- The reporting institution is treating or managing the recurrence, progression, or subsequent treatment of a previously-diagnosed malignancy.
- Patients for whom the reporting institution developed a treatment plan or provided “second opinion’’ services but the diagnosis and treatment were performed elsewhere.

Class 4 includes cases that were diagnosed and/or received their first-course of treatment at the reporting institution **BEFORE** the registry's reference date. The reporting institution manages or treats a recurrence or progression of that cancer **AFTER** the registry's reference date.

- Assign a class of case 4 also if it is unknown whether the reporting institution delivered the first-course of treatment.

Class 5 refers to an incidental finding of cancer at autopsy. There was no suspicion of cancer before the autopsy.

Class 6 includes patients who were both diagnosed and received all of their first-course of treatment in a staff physician's office. "Staff physician" refers to any medical staff with admitting privileges at the reporting facility.

Class 7 includes pathology report only. The patient does not enter the reporting facility at any time for diagnosis or treatment. This excludes patients diagnosed as autopsy only.

Class 8 should be used only by a central registry (e.g. NJSCR) and includes:

- Diagnoses based on death certificates only.

Class 9 can be used for consult only cases otherwise it should be used only by a central registry and includes:

- Unknown if previously diagnosed.
- Previously diagnosed, date unknown.
- Unknown if previously treated.

Demographic Data

Last Name, First Name, Middle Name

Record patient's last name, first name and middle name, if the middle name is not available, use the middle initial of the patient. Do not use any spaces or punctuation (e.g. ONEIL). Hyphenated names are allowed (e.g. SMITH-BROWN). Please spell names correctly.

Alias or Maiden Name

If maiden or alias name is known, record the name. If the patient uses an alias for the first, last name or both first and last name, record the last name alias followed by a blank space and the first name (alias). Leave the space blank if the patient does not have a maiden name or uses an alias.

Name - Prefix/Suffix

Abbreviated titles may be used. Do not use periods or spaces (e.g., MS, MD).

Address at Diagnosis

SEER registries collect information of place of residence at diagnosis. The SEER rules for determining residency at diagnosis are either identical or comparable to rules used by the US Census Bureau.

Record the patient's residence when the tumor was first diagnosed and treated. It should be noted the patient's address at diagnosis may be different than the patient's current address. The address should be the residence, not the mailing address. If the patient has multiple tumors, the address at diagnosis may be different for each subsequent primary. If the address is unknown, record UNKNOWN.

Special Notes about Address:

- Whenever possible the residence city should be recorded, not the mailing city as these may be different.
- Do not record a temporary residence, such as a friend's or relative's.
- Use a street address if available when a P.O. Box is given. Post Office Box is not a reliable source to identify the residency at diagnosis; it does not provide accurate geographical information for analyzing cancer incidence.
- For institutionalized patients, including those who are incarcerated, living in nursing, convalescent or rest homes, use the address of the institution where they reside.
- For persons without a residence, use the address of the shelter or the hospital where diagnosed.
- For persons with multiple residences, use the address they specify as their usual residence.
- If the usual residence is not known or the information is not available, code the residence the patient specifies as the place of residence.
- For military personnel, use the residence of the installation. If living off-base, use the individual's residence address.
- College students are considered residents of the area in which they are living while attending college, but children in boarding schools below the college level are considered residents of their parents' home.
- Use residency information from a death certificate only when the residency from other sources is coded as “unknown”. Review each case carefully and apply the US Census Bureau/SEER rules for determining residence. The death certificate may give the person’s previous home address rather than the nursing home address as the place of residence; use the nursing home address as the place of residence.
- Do not use legal status or citizenship to code residence.
- For persons with more than one residence (such as “snowbirds”), code the residence where the patient spends the majority of time (usual residence). If the usual residence is not known or the information is not available, code the residence the patient specifies at the time of diagnosis.
- Code the place of usual residence rather than the temporary address for migrant workers, educators temporarily assigned to a university in a SEER area, persons temporarily residing with family during cancer treatment, and military personnel on **temporary** duty assignments (TDY).

Number and Street Address

Record the number and street address at the time of diagnosis. Use a blank between numbers and words (e.g.123 Fifth Avenue NW, Apt. 7B**).**

A street address should include:

- street number
- prefix directional (e.g., E, W, SE, NW, etc.)
- street name
- street type (e.g., St, Ave, Ln, Tpk., etc.)
- suffix directional (e.g., W, NE, S, etc.)

For example, an address with four of the most commonly given components would look like:

427 E Maple St. or 211 Broadway Ave SW

Apartment numbers, building numbers, etc., can be included but they MUST be added at the end if there is space. Whenever possible, avoid using facility names (e.g., nursing home, hospital), Rural Routes and P.O. Box numbers in the ADDRESS field. Enter the patient's street address of residence whenever possible.

City

Enter the name of the city or town of residence, not the location of the post office box number. Do not use abbreviations. If city is unknown, type out the word UNKNOWN.

County

Record the *three-digit* county code for the address at diagnosis listed below:

COUNTY NAME	CODE	COUNTY NAME	CODE
Atlantic	**001**	**Mercer**	**011**
Bergen	**003**	**Middlesex**	**023**
Burlington	**005**	**Monmouth**	**025**
Camden	**007**	**Morris**	**027**
Cape May	**009**	**Ocean**	**029**
Cumberland	**011**	**Passaic**	**031**
Essex	**013**	**Salem**	**033**
Gloucester	**015**	**Somerset**	**035**
Hudson	**017**	**Sussex**	**037**
Hunterdon	**019**	**Union**	**039**
		Warren	**041**

ZIP Code

Record the patient's five-digit or nine-digit ZIP code corresponding to the street address. Code 999999999 if the patient is a US or Canadian resident but the postal code is unknown. Code 888888888 if the patient is a foreign resident and the foreign country's postal code is unknown.

State

Record the standard two-letter U.S. Postal Service abbreviation for the patient's state of residence at the time of diagnosis. For foreign residents, code the state abbreviation as XX.

Alabama	AL	Kentucky	KY	North Dakota	ND
Alaska	AK	Louisiana	LA	Ohio	OH
Arizona	AZ	Maine	ME	Oklahoma	OK
Arkansas	AR	Maryland	MD	Oregon	OR
California	CA	Massachusetts	MA	Pennsylvania	PA
Colorado	CO	Michigan	MI	Rhode Island	RI
Connecticut	CT	Minnesota	MN	South Carolina	SC
Delaware	DE	Mississippi	MS	South Dakota	SD
District of Columbia	DC	Missouri	MO	Tennessee	TN
Florida	FL	Montana	MT	Texas	TX
Georgia	GA	Nebraska	NE	Utah	UT
Hawaii	HI	Nevada	NV	Vermont	VT
Idaho	ID	New Hampshire	NH	Virginia	VA
Illinois	IL	New Jersey	NJ	Washington	WA
Indiana	IN	New Mexico	NM	West Virginia	WV
Iowa	IA	New York	NY	Wisconsin	WI
Kansas	KS	North Carolina	NC	Wyoming	WY

Other:

American Samoa	AS
Guam	GU
Mexico	MX
Puerto Rico	PR
Virgin Islands	VI

Canada:

Alberta	AB	Nova Scotia	NS
British Columbia	BC	Ontario	ON
Labrador	LB	Prince Edward Island	PE
Manitoba	MB	Quebec	PQ
New Brunswick	NB	Saskatchewan	SK
Newfoundland	NF	Yukon	YT
Northwest Territories	NT	Canada, NOS	CN

Current Address

This field is different from Patient's Address at Diagnosis and should be updated throughout the lifetime of the patient. It provides useful information necessary for follow-up. List the patient's current street name and number, city, state and zip code.

Social Security Number

Record the patient's social security number. This is an important identification field. Numbers should be accurately listed without the use of dashes. Use 9's for unknown numbers. Do not enter a Social Security number that ends with a B or D. This is the spouse's social security number.

Please Note: The Medicare claim number is *not* always identical to the social security number.

Sex

Record the patient's sex.

1 Male
2 Female
3 Other (hermaphrodite)
4 Transsexual
9 Not stated/ Unknown

Age at Diagnosis

Record the patient's age at the time of initial diagnosis, in completed years. Some registry software automatically calculate age when date of birth and date of diagnosis are recorded.

000 Less than one year old
001 One year old, but less than two years old
002 Two years old
" (Actual age in years)
100 One hundred years old
999 Unknown age

If year of birth and year of diagnosis are known, but age is unknown, calculate age at diagnosis.

Date of Birth

Record the exact date of the patient's birth in month, day, century and year. Estimate the year of birth when exact information is not available. It is preferable to estimate rather than to code the year as unknown. If there is no basis for estimating birth year, enter **9999** for the year.

Example: Patient is 50 years old when diagnosed on May 1, 2005. The medical record does not contain the birth date. Record **99** for month, **99** for day and estimate the birth year as 1955. The complete birth date would be 99/99/1955.

Place of Birth

Enter the name of the state, county or territory where the patient was born. Use the three-digit SEER Geocodes for Place of Birth in Appendix B. These codes contain all states as well as foreign countries.

Race 1, 2, 3, 4, 5

Code the primary race(s) of the patient in fields Race 1, Race 2, Race 3, Race 4, and Race 5. If race is not recorded on the face sheet of the medical record, please check to see if it has been recorded elsewhere in the chart. Every attempt should be made to obtain the correct race code.

Please note that race is coded separately from "Hispanic ethnicity".

RACE	CODE	RACE	CODE
White	01	Micronesian, NOS	20
Black	02	Chamorran	21
American Indian, Aleutian, Eskimo	03	Guamanian, NOS	22
Chinese	04	Polynesian, NOS	25
Japanese	05	Tahitian	26
Filipino	06	Samoan	27
Hawaiian	07	Tongan	28
Korean	08	Melanesian, NOS	30
Asian Indian, Pakistani	09	Fiji Islander	31
Vietnamese	10	New Guinean	32
Laotian	11	Other Asian, incl. Asian, NOS & Oriental, NOS	96
Hmong	12	Pacific Islander, NOS	97
Kampuchean (Cambodian)	13	Other	98
Thai	14	Unknown	99

Special Notes on Coding Race:

1. If no race is stated in the medical record, or if the stated race cannot be coded, review the documentation for a statement of a race category.
2. If a person's race is a combination of white and any other race(s), code the appropriate other race(s) first and code white in the next race field.
3. If a person's race is a combination of Hawaiian and any other race(s), code Race 1 as 07 Hawaiian and code the other races in Race 2, Race 3, Race 4, and Race 5 as appropriate.

   Example: Patient is described as Japanese and Hawaiian. Code Race 1 as 07 Hawaiian and Race 2 as 05 Japanese.

4. If the person is not Hawaiian, code Race 1 to the first stated non-white race.

   Example: Patient is stated to be Vietnamese and Black. Code Race 1 as 10 Vietnamese, Race 2 as 02, Black, and the remaining race fields as 88.

5. The fields Place of Birth, Race, Marital Status, Name, Maiden Name, and Hispanic Origin are inter-related. Use the following guidelines in priority order:

   Code the patient's stated race, if possible.

   Example 1*:* Patient is stated to be Japanese. Code as 05 Japanese.

   Example 2: Patient is stated to be German-Irish. Code as 01 White.

   Example 3: Patient is described as Arabian. Code as 01 White.

   Exception*:* When the race is recorded as Oriental, Mongolian, or Asian (coded to 96 Other Asian) and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation, code the race based on birthplace information.

6. If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race, other than to list the non-white race(s) first.

   Example**:** The patient is described as Asian-American with Korean parents. Code race as 08 Korean because it is more specific than 96 Asian [-American].

   If race is unknown or not stated in the medical record and birth place is recorded, in some cases race may be inferred from the nationality.

   Example 1: Record states: "this native of Portugal..." Code race as 01 White.

   Example 2*:* Record states: "this patient was Nigerian..." *Code race as 02.*

   Exception: If the patient's name is incongruous with the race inferred on the basis of nationality, code Race 1 through Race 5 as 99, Unknown.

7. Use of patient's name in determining race:

   a. Do not code race from name alone, especially for females with no maiden name given.

   b. In general, a name may be an indicator of a racial group, but should not be taken as the only indicator of race.

   c. A patient's name may be used to identify a more specific race code.

      ***Example 1*:** Race reported as Asian, name is Hatsu Mashimoto. Code race as 05 Japanese.

      ***Example 2**:* Birthplace is reported as Guatemala and name is Jose Chuicol [name is identified as Mayan]. Code race as 03 Native American.

   d. A patient's name may be used to infer Spanish ethnicity or place of birth, but a Spanish name alone (without a statement about race or place of birth) cannot be used to determine the race code. Refer to ethnicity guidelines for further information.

      Example: Alice Gomez is a native of Indiana (implied birthplace: United States). Code Race 1 through Race 5 as 99 Unknown because nothing is known about her race.

8. Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually white. Do NOT code a patient stated to be Hispanic or Latino as 98 Other Race in Race 1 and 88 in Race 2 through Race 5.

9. Death certificate information may be used to supplement antemortem race information only when race is coded unknown in the patient's record or when the death certificate information is more specific.

10. ***Cases diagnosed prior to January 1, 2000:***
    For cases diagnosed priory to January 1, 2000, race 2 through 5 must be blank unless the patient has multiple primaries and at least one primary is diagnosed on or after January 1, 2000. In this case, the race codes must be identical on each record.

11. ***Cases diagnosed on or after January 1, 2000:***
    a. If only one race is reported for the person, use code 88 for the remaining race fields.
    b. If the patient is multiracial, code all races using items Race 1 through Race 5.
    c. If any race code is 99, then ALL race codes must be 99.
    d. If Race 1 is 01-98, Race 2 through Race 5 CANNOT be 99.
    e. If more than 1 race is coded, and if any other race is 88, then all subsequent race codes must be 88.
    f. A unique race code (other than 88 or 99) can only be coded once in Race 1 through Race 5. For example, do not code 01 White in Race 1 for one parent and 01 White in Race 2 for the other parent.
    g. Do not code 96 Other Asian in a subsequent race field if a specific Asian race has already been coded.

Spanish/Hispanic Surname

Code Spanish/Hispanic origin in this field. All available information should be used to determine the Spanish/Hispanic origin including the stated ethnicity in the medical record, stated Hispanic Origin on the death certificate, birthplace information in the history, and or language spoken. A person of Spanish/Hispanic origin may be of any race. Record applicable codes 1-8 if the patient has identified himself/herself as a specific Hispanic subgroup. Code 7 is assigned by the NJSCR.

SURNAME/ORIGIN	CODE
Non-Spanish/Non-Hispanic *	0
Mexican (includes Chicano)	1
Puerto Rican	2
Cuban	3
South or Central American (except Brazil)	4
Other specified Spanish/Hispanic origin (includes European)	5
Spanish, NOS; Hispanic, NOS; Latino, NOS (There is evidence other than surname or maiden name that the person is Hispanic, but he/she cannot be assigned to any category of 1-5)	6
Spanish surname only (Assigned by NJSCR only)	7
Dominican Republic (Effective with Cases Diagnosed on or after 1/1/2005)	8
Unknown whether Spanish/Hispanic	9

* Code Portuguese, Brazilians and Filipinos as non-Spanish, 0.

Marital Status

The field reflects the patient's marital status at diagnosis for each primary tumor.

1	Single (never married)	4	Divorced
2	Married (including common law)	5	Widowed
3	Separated	9	Unknown

Persons of the opposite sex living together as part of a long-term personal relationship would be coded to 2, Married (including common law).

Persons of the same sex living together as part of a long-term personal relationship would be coded according to their legal status (usually single, separated, divorced, or widowed).

Usual Occupation

Record the patient's usual occupation regardless of whether the patient is currently employed or retired. Usual occupation refers to the type of job the individual performed during most of his/her working life. If the patient was a housewife/house husband and did **NOT** work outside the home for most of her/his adult life, record housewife or house husband. If the patient is a student and has never been employed, record as "never worked." If no information is available record "unknown." This data item applies only to patients who are 14 years or older at the time of diagnosis.

Usual Industry

Record the type of activity carried on by the business/industry where the patient was employed for the longest time before diagnosis of this tumor (e.g. school, auto repair, food preparation). If possible, try to distinguish among "manufacturing," "wholesale," "retail," and "service". If type of industry is not known, record the name of company. If no information is available, code unknown. Do not record retired.

Managing Physician

This is the person responsible for the overall management of the patient during diagnosis and/or treatment of this primary. The physician's name may change with subsequent primaries. If so, record physician's name for each primary separately.

Medical Record Number

Record the medical record number or patient's identification number found in the patient's chart. This number is usually assigned by the reporting institution's Health Information Management (HIM) Department. If a patient has not been assigned one, record UNK. Record standard abbreviations for departments that do not use HIM medical record numbers such as Radiation Therapy.

Cancer Identification Items

Date of Diagnosis

The date of diagnosis is an 8-digit field representing the first date the diagnosis of cancer was made by a *recognized medical practitioner*. Record the month, day, century, and year. The first diagnosis can be clinical
and may or may not be histologically confirmed. Do not change the diagnosis date if a later biopsy or cytology confirms the diagnosis.

Example: January 1, 2001 record as 01-01-2001.

Note:

- Each new primary will have its own date of diagnosis.
- For "Death Certificate-Only" the date of diagnosis is the date of death.
- For "Autopsy-Only" cases the date of diagnosis is the date of death.
- In the absence of an exact date of diagnosis, use an approximation from the table below for the month.
- Code 9 for unknowns: 99 for unknown month, 99 for unknown day and 9999 for unknown century and year.
- If the patient receives first-course of therapy and there is no information about the diagnosis, use the date of admission as the date of diagnosis.
- If the patient receives first-course of cancer-directed therapy and there is not a diagnosis date or an admission date, code the date of first treatment as the diagnosis date.
- Positive tumor markers alone are not diagnostic of cancer. Use the date of clinical, histologic, or positive cytologic information as the date of diagnosis.
- The first date of diagnosis may be clinical. Do not change the date of diagnosis when a clinical diagnosis is confirmed later by a positive histology or cytology.

Date of Diagnosis (Continued)

Descriptive Term	Date Code
Spring	April
The middle of the year	July
The fall of the year	October
The winter of	Try to determine if this means the beginning or end of the year. If there is no basis for an approximation, code the month of diagnosis as 99.

Sequence Number

This item describes the number and sequence of all reportable malignant, in situ, benign and borderline primary tumors which occur over the lifetime of a patient. The sequence numbers for neoplasms whose histologies were associated with behavior codes that changed from in situ/malignant to benign/borderline or vice versa during the conversion from ICD-O-2 to ICD-O-3 should not be re-sequenced. Please refer to Appendix J for detailed tables regarding sequencing.

Malignant Tumors

00 One primary only
01 First of two or more primaries
02 Second of two or more primaries
" (Actual number of this primary)
10 Tenth of ten or more primaries
11 Eleventh of eleven or more primaries
"
99 Unspecified sequence number

Sequence numbers describe the chronology of diagnoses of all primary malignant and/or in situ cancers over the entire lifetime of the person regardless of where or when diagnosed. It counts the occurrence of independent, primary tumors excluding basal and squamous cell tumors of the skin that are not reportable.

Example: If a patient has a bladder cancer diagnosed in 1999 with a sequence number of "00" and a lung cancer diagnosed in 2004, the sequence number of the lung cancer is coded "02." The sequence number of the bladder cancer is updated to "01".

Rules for determining multiple primaries and the reportability requirements for each diagnosis year should be used to decide which primaries need to be sequenced.

Non-malignant Tumors (Benign and Borderline)

Benign and borderline sequence codes are independent of the malignant sequence codes.

60	Only one non-malignant tumor or central registry-defined neoplasm
61	First of two or more non-malignant tumors or central registry-defined neoplasms
62	Second of two or more non-malignant tumors or central registry-defined neoplasms
..	..
87	Twenty-seventh of twenty-seven
88	Unspecified or unknown sequence number of non-malignant tumor or central-registry defined neoplasms. (Sequence number 88 can be used if there is a non-malignant tumor and its sequence number is unknown. If there is known to be more than one non-malignant tumor, then the tumors must be sequenced.)
98	Cervix carcinoma in situ (CIS/CIN III, Diagnosis Years 1996-2002)

TABLE A-1. Sequence Number: Code Assignment by Type of Neoplasm.	
***In Situ*/Malignant as Required by NJSCR Based on Diagnosis Year**	**Seq Num (Numeric Series)**
In Situ (behavior code = 2), Cervix CIS/CIN III (Diagnosis Year before 1996), Includes VIN III, VAIN III, AIN III	00-35
Malignant (Behavior Code = 3)	00-35
Juvenile Astrocytoma, Diagnosis Year 2001+*	00-35
Invasive Following *In Situ* - New Primary as Defined by CoC	00-35
Invasive Following *In Situ* - New Primary as Defined by SEER	00-35
Federally Required Sequence Number Unknown or Unspecified	99
Non-Malignant Tumors as Required Based on Diagnosis Year	**Seq Num (Numeric Series)**
Examples:	
Benign Brain YEAR 2004+	60-87
Borderline Ovarian, Diagnosis Year 2001+	60-87
Other Borderline/Benign	60-87

Example: A patient is diagnosed with breast cancer in 2000 and is sequenced as "00". In 2004, the patient is diagnosed with a benign meningioma. The breast primary remains "00" and the meningioma is sequenced as "60".

Primary Site

For cases diagnosed 1/1/2001 and later, code the primary site using the topography section of the *International Classification of Diseases for Oncology*, Third Edition (ICD-O-3).

The ICD-O-3 has topography codes listed in two sections; the first is a numeric listing by code number, the second is an alphabetic listing by anatomic site. The topography code consists of a lead character (the letter 'C') followed by two numeric digits, a decimal point, then one additional numeric digit. The decimal point is not entered as part of the code.

Example: The pathology report says the primary site is the cardia of the stomach. The code (C16.0) is found in the Alphabetic Index under either "stomach" or "cardia." Enter the code as C160; do not record the decimal point.

Coding Instructions

Site-Specific Topography Terms (See the Coding Guidelines for Topography and Morphology in the introduction of the ICD-O-3 for additional details).

Refer to "Determining Multiple Primaries" in the first section of this manual to determine the number of primaries. Use all of the information for a single primary to code the site.

1. Code the **site** in which the **primary tumor originated, even if it extends into an adjacent "subsite**."

   Example 1: Final diagnosis is adenocarcinoma of the upper lobe of the right lung. Code the topography to lung, upper lobe (C341).

   Example 2: Pathology report shows adenocarcinoma arising in an ectopic patch of endometriosis on the sigmoid colon. Code the primary site to sigmoid colon (C187), the site in which the cancer originated.

   Example 3: Patient has a right brachial cleft cyst; the pathology report identifies an adenocarcinoma arising in an ectopic focus of thyroid tissue within the brachial cleft cyst. Thyroidectomy pathology is negative. Code primary site to brachial cleft (C104).

   Example 4: The patient had a total hysterectomy with a bilateral salpingo-oophorectomy ten years ago for benign reasons. She now has widespread cystadenocarcinoma in the peritoneum. Code the primary site to peritoneum, NOS (C482). (The chart may or may not state that the patient has extra-ovarian carcinoma).

   Example 5: The patient has a 4 cm tumor in the right breast. The tumor originated in the upper inner quadrant and extends into the lower inner quadrant. Code primary site to upper inner quadrant of breast (C502).

2. Use the SEER Site Grouping Table in the Rules for Determining Multiple Primaries section to code the primary site specified in the table in those rare cases when:

   a. A single tumor overlaps adjacent **sites** in the same group
   b. Multiple tumors reported as a single primary involve adjacent **sites** in the same group

   Example: The patient has a 5cm tumor overlapping the base of tongue and anterior 2/3 of tongue. Use the SEER Site Grouping Table to determine the correct code for the primary site, C029 (Tongue, NOS).

3. Code the last digit of the primary site code to '8' when a **single tumor overlaps** an adjacent **subsite**(s) of an organ and the point of origin cannot be determined.

   Example: The patient has a 5cm tumor that involves the dorsal surface and anterior 2/3 of tongue. Code the primary site to C028 (overlapping lesion of tongue).

4. Code the last digit of the primary site code to '9' for single primaries, when **multiple tumors arise** in **different subsites** of the same anatomic site, unless the subsite is defined in one of the site groups listed in the SEER Site Grouping Table. Refer to the SEER Site Grouping Table in the section entitled "How to Determine Same vs. Different Primary Site" to determine the primary site code for specified site groups.

   Example 1: During a TURB, the physician describes multiple papillary tumors in the bladder neck (C675) and the lateral wall of the bladder (C672). Code the primary site as bladder, NOS (C679).

   Example 2: Patient has an infiltrating duct tumor in the upper outer quadrant (C504) of the right breast and another infiltrating duct carcinoma in the lower inner (C503) quadrant of the right breast. Code the primary site as breast, NOS (C509).

5. Some histology/behavior terms in ICD-O-3 have a **related site code** in parenthesis; for example, hepatoma (C220).

   a. Code the site as documented in the medical record and ignore the suggested ICD-O-3 code when a primary site is specified in the medical record.

      Example: The pathology report says "ductal carcinoma of the head of the pancreas." The listing in ICD-O-3 is ductal carcinoma 8500/3 (C50). Code the primary site to head of pancreas, NOT to breast as suggested by the ICD-O-3.

   b. Use the site code suggested by ICD-O-3 when the primary site is the same as the site code suggested or the primary site is unknown.

      Example 1: The biopsy is positive for hepatoma, but there is no information available about the primary site. Code the primary site to liver (C220) as suggested by ICD-O-3.

Example 2: The patient has an excision of the right axillary nodes which reveals metastatic infiltrating duct carcinoma. The right breast is negative. The ICD-O-3 shows duct carcinoma (8500) with a suggested site of breast (C50_). Code the primary site as breast, NOS (C509).

6. Code the primary site, not the metastatic site. If a tumor is metastatic and the primary site is unknown, code the primary site as unknown (C809).

7. When the medical record does **not** contain **enough information** to assign a primary site:

    a. Consult a physician advisor to assign the site code.
    b. Use the NOS category for the organ system or the Ill Defined Sites (C760-C768) if the physician advisor cannot identify a primary site.
    c. Code Unknown Primary Site (C809) if there is not enough information to assign an NOS or Ill Defined Site category.

Leukemia

Code leukemia primaries to bone marrow (C421); blood cells originate in the bone marrow.

Lymphoma

Definitions

Extralymphatic: Originating in tissue or an organ that is not a part of the lymphatic system.

Extranodal lymphoma: Lymphoma originating in tissue or organ other than lymph nodes. Lymphatic system organs may be extranodal . (e.g., Spleen is a lymphatic system organ and is also extranodal.)

Lymphatic system: An umbrella term that includes: lymph nodes, spleen, thymus, tonsils, Waldeyer's ring, and Peyer's patches.

Nodal lymphoma: A lymphoma originating in lymph nodes.

Lymphoma Coding Instructions

1. When a single lymph node chain is involved, code that chain as the primary site.

2. When **multiple lymph node chains** are involved at the time of **diagnosis**, do not simply code the lymph node chain that was biopsied.

    a. If it is possible to determine where the disease originated, code the primary site to that lymph node chain.
    b. If multiple lymph node chains are involved and all involved chains are located in the same lymph node region (i.e. the same primary site code) and it is not possible to determine the lymph node chain where the disease originated, code the primary site to lymph nodes of the specified nodal region (C77_).

c. If multiple lymph node chains are involved and the involved chains are in different lymph node regions, code C778 (lymph nodes of multiple regions).

3. When the lymphoma is **extranodal and is**

   a. **Confined to the organ of origin,** code the organ of origin.

      Example: Pathology from a stomach resection shows lymphoma. No other pathologic or clinical disease identified. Code the primary site as stomach, NOS (C169).

   b. Present in an **extranodal organ/site and** in that organ/site's **regional lymph nodes,** code the extranodal organ/site as the primary site.

      Lymphomas that are primary in an extranodal organ/site may metastasize to that organ/site's regional lymph nodes. In rare cases a lymphoma may spread from the lymph node to an extranodal site or extralymphatic organ by direct extension.

      Example 1: Lymphoma is present in the spleen and splenic lymph nodes. Code the primary site to spleen (C422).

      Example 2: Lymphoma is present in the stomach and the gastric lymph nodes. Code the primary site to stomach, NOS (C169).

   c. Present in **extranodal organ(s)/site and non-regional lymph nodes**, consult the physician to determine the primary site. If a site cannot be determined, code to Lymph Node, NOS (C779).

4. If the **primary site is unknown** or not given:

   a. Code retroperitoneal lymph nodes if described as retroperitoneal mass.
   b Code inguinal lymph nodes if described as inguinal mass.
   c. Code mediastinal lymph nodes if described as mediastinal mass.
   d. Code mesenteric lymph nodes if described as mesenteric mass.
   e. If the primary site is unknown, code Lymph Nodes, NOS (C779).

   Exception*:* Code unknown primary site (C809) only when there is no evidence of lymphoma in lymph nodes and/or the medical record documents that the physician suspects that it is an extranodal lymphoma.

Esophagus

There are two systems that divide the esophagus into three subsites. The first system divides the esophagus into the upper third, middle third, and lower third. The second system describes the subsites as the cervical esophagus, the thoracic esophagus and the abdominal esophagus. The subsites for these two different systems are not identical. Assign the ICD-O-3 topography code that describes the primary site documented in the medical record. See the SEER *Self Instructional Manual for Tumor Registrars, Book 4* for illustrated descriptions of each system.

Kaposi Sarcoma

Kaposi sarcoma is a rare condition. When not AIDS-related, it usually presents as localized disease with an easily recognized primary site.

AIDS-related Kaposi sarcoma usually presents as a disseminated disease with involvement of mucosal surfaces, visceral surfaces of organs, and skin. It is important to review consecutive records carefully to determine the extent of involvement at diagnosis. Review of a single record may reveal only the site being treated during that admission.

1. Code Kaposi to the **site in which it arises**.
2. If the Kaposi is present in the **skin and another site** simultaneously, code to the specified skin site, (C44_).
3. If the **primary site is unknown** or cannot be determined, code skin, NOS (C449).

Sarcoma

The majority of sarcomas arise in mesenchymal or connective tissues that are located in the musculoskeletal system. The musculoskeletal system includes the fat, muscles, blood vessels, deep skin tissues, nerves, bones and cartilage. The default code for sarcomas of unknown primary site is C499 rather than C809.

Sarcomas may also arise in the walls of hollow organs and in the viscera covering an organ. Code the primary site to the organ of origin.

Example: The pathology identifies a mixed Mullerian tumor of the uterus. Code the site to uterus, NOS (C559).

Laterality

Laterality describes the side of a paired organ or side of the body on which the reportable tumor originated. For each primary you need to determine whether laterality should be coded.

Starting with cases diagnosed January 1, 2004 and later, laterality is coded for select invasive, benign, and borderline primary intracranial and CNS tumors.

Codes

0 Not a paired site
1 Right: origin of primary
2 Left: origin of primary
3 Only one side involved, right or left origin unspecified
4 Bilateral involvement, lateral origin unknown; stated to be single primary
9 Paired site, but no information concerning laterality; midline tumor

Coding Instructions

1. Code laterality using codes 1-9 for all of the sites listed in the following table.
2. Code the side where the primary tumor originated.

    a. Assign **code 3** if the laterality is not known but the tumor is confined to a single side of the paired organ.

        Example: Pathology report: Patient has a 2 cm carcinoma in the upper pole of the kidney. Code laterality as 3 because there is documentation that the disease exists in only one kidney, but it is unknown if the disease originated in the right or left kidney.

    b. **Code 4** is seldom used EXCEPT for the following diseases:
        i. Both ovaries involved simultaneously, single histology
        ii. Bilateral retinoblastomas
        iii. Bilateral Wilms tumors

Note: Laterality may be coded for sites other than those required above.

3. Assign **code 9** when there is a midline tumor or when the disease originated in a paired site, but the laterality is unknown.

    Example 1: Admitting history says patient was diagnosed with lung cancer based on positive sputum cytology. Patient is treated for painful bony metastases. There is no information about laterality in the diagnosis of this lung cancer.

    Example 2: Patient has an excision of a melanoma located just above the umbilicus. Assign code 9 for a midline tumor.

Sites for Which Laterality Codes Must Be Recorded

ICD-O-3 Code	Site or Subsite
C079	Parotid gland
C080	Submandibular gland
C081	Sublingual gland
C090	Tonsillar fossa
C091	Tonsillar pillar
C098	Overlapping lesion of tonsil
C099	Tonsil, NOS
C300	Nasal cavity (excluding nasal cartilage, nasal septum)
C301	Middle ear
C310	Maxillary sinus
C312	Frontal sinus
C340	Main bronchus (excluding carina)
C341-C349	Lung
C384	Pleura
C400	Long bones of upper limb, scapula, and associated joints
C401	Short bones of upper limb and associated joints
C402	Long bones of lower limb and associated joints
C403	Short bones of lower limb and associated joints
C413	Rib, clavicle (excluding sternum)
C414	Pelvic bones (excluding sacrum, coccyx, symphysis pubis)
C441	Skin of the eyelid
C442	Skin of the external ear
C443	Skin of other and unspecific parts of the face (if midline, assign code 9)
C445	Skin of the trunk (if midline, assign code 9)
C446	Skin of upper limb and shoulder
C447	Skin of the lower limb and hip
C471	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C472	Peripheral nerves and autonomic nervous system of the lower limb and hip
C491	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C492	Connective, subcutaneous, and other soft tissues of the lower limb and hip
C500-C509	Breast
C569	Ovary
C570	Fallopian tube
C620-C629	Testis
C630	Epididymis
C631	Spermatic cord
C649	Kidney, NOS
C659	Renal pelvis
C669	Ureter
C690-C699	Eye and adnexa
C700	Cerebral meninges, NOS (Effective with cases diagnosed 1/1/2004)
C710	Cerebrum (Effective with cases diagnosed 1/1/2004)
C711	Frontal lobe (Effective with cases diagnosed 1/1/2004)
C712	Temporal lobe (Effective with cases diagnosed 1/1/2004)
C713	Parietal lobe (Effective with cases diagnosed 1/1/2004)
C714	Occipital lobe (Effective with cases diagnosed 1/1/2004)
C722	Olfactory nerve (Effective with cases diagnosed 1/1/2004)
C723	Optic nerve (Effective with cases diagnosed 1/1/2004)
C724	Acoustic nerve (Effective with cases diagnosed 1/1/2004)
C725	Cranial nerve, NOS (Effective with cases diagnosed 1/1/2004)
C740-C749	Adrenal gland
C754	Carotid body

Note: A laterality code of 1-4 or 9 **must** be assigned for the above sites except as noted. If the site is not listed on the table, assign code 0 for laterality. Laterality **may** be coded for sites other than those required above.

DETERMINING MULTIPLE PRIMARIES: SOLID MALIGNANT TUMORS

See separate sections for hematopoietic primaries and benign and borderline primary intracranial and central nervous system tumors (CNS).

The determination of how many primary cancers a patient has is a medical decision. Operational rules are needed in order to ensure consistency of reporting. Basic factors include the site of origin, the date of diagnosis, the histologic type, the behavior of the neoplasm (such as in situ versus malignant), and laterality.

In general if there is a difference in the site where the cancer originates, it is fairly easy to determine whether it is a separate primary, regardless of dates of diagnosis and differences in histology.

The following rules were taken from the SEER Program Manual 2004.

Terms

The words "**tumor**," "**neoplasm**," "**mass**," and "**lesion**" are used interchangeably throughout this section. The terms "**original**" and "**initial**" are synonymous**.**

Definitions:

Focal: Limited to one specific area

Foci/focus: The starting point of a disease process, a single cell.

Laterality describes the right or left side of the body or the right or left of a paired organ such as the right kidney or the left kidney. Unilateral describes a single organ/side. Bilateral describes both organs/sides.

Metachronous tumors are multiple tumors or lesions that occur greater than two months from the original/initial diagnosis.

Multicentric: A primary tumor with satellites in surrounding tissue.

Multifocal: Multiple tumors arising from two or more locations.

Multiple primaries: Describes two or more independent primary reportable neoplasms.

Non-synchronous (**Metachronous**) tumors are multiple masses or lesions that occur greater than two months from the original/initial diagnosis.

Paired Organ: Two separate organs, a right and a left; for example, right breast and left breast.

Primary site is the anatomical portion of the body where the cancer originated.

Simultaneous tumors are multiple tumors identified at the time of diagnosis.

Synchronous tumors are multiple tumors diagnosed within two months of the original/initial diagnosis.

Single primary describes one distinctive reportable cancer.

Definitions (Continued):

Single Tumor is a single lesion. A single tumor may **invade regional** organs by traveling along the mucosa or extending through the organ wall into **regional** tissue or organ. A single tumor may have **multiple or mixed** histologies.

Example 1: Colon primary: a large tumor originating in the ascending colon with intramucosal spread into the transverse colon. Abstract as a single primary and record the primary site as ascending colon. (The spread into the transverse colon is reflected in the staging of disease extent.)

Example 2: The patient has multiple papillary urothelial bladder tumors with in situ spread into the ureters. Abstract as a single primary and record the primary site as bladder. (Mucosal spread of a urinary tract tumor may be called "field affect" or "regional diathesis").

HOW TO DETERMINE SAME VS. DIFFERENT PRIMARY SITE (BASED ON ICD-O-3 TOPOGRAPHY CODE)

Main Rule: Each category (first three characters, including the letter "C") as delineated in ICD-O-2 or ICD-O-3 is considered to be a separate site.

1. The **third numeric digit** after the 'C' describes a subsite, or particular area, of the organ. It is **not used** to define individual (different) sites.

   Example: C16_ is the code for stomach and the third numeric digit, C163 describes the part of the stomach called the antrum.

   ***Exceptions*:** For certain specific sites, a difference in the third numeric digit designates a different primary site for abstracting and coding purposes:

   Colon (C18_)
   Anus and anal canal (C21_)
   Bones, joints, and articular cartilage (C40_-C41_)
   Melanoma of skin (C44_)
   Peripheral nerves and autonomic nervous system (C47_)
   Connective, subcutaneous and other soft tissues (C49_)

   Example: If the patient has a melanoma on the skin of the scalp (C444) and another melanoma on the calf of the right leg (C447), these are two different primary sites because the third numeric digit of the site code is different. The registrar prepares two abstracts, one for each site.

2. If the **first two numeric digits** after the C are **identical**, it is the **same site**.

   Example: If there is a tumor in the lower lobe of the right lung (C343) and a separate tumor in the upper lobe of the right lung, (C341), it is the same site. Note: This does not necessarily mean it will be one primary cancer, as it also depends on the histology of each tumor.

   Possible exception: **Paired organ**: There are specific rules for paired organs, which are described elsewhere in this section.

HOW TO DETERMINE SAME VS. DIFFERENT PRIMARY SITE (BASED ON ICD-O-3 TOPOGRAPHY CODE) (Continued)

3. If there is any difference in the first two numeric digits after the C, it is a **different** site.

   Example: Stomach, NOS (C169) and small intestine, NOS (C179) are different sites because the second numeric digit is not identical.

   Exception: **ICD-O-1** and **ICD-O-2/ICD-O-3 groupings**: The second edition of the *International Classification of Diseases for Oncology* (ICD-O-2) split several site codes into categories having differences in the second numeric digit after the C. The second and third edition ICD-O topography codes are identical. The SEER Program continues to use most of the ICD-O-1 subcategory site groupings to prevent artificial changes in site-specific incidence.

   Please see the table on the next page. When the patient has **multiple independent** tumors, any combination of site codes within the same row in the table is the same primary site. Use this table for in situ and/or invasive tumors. (Do not use this table for a single tumor with extension into another site.)

   To use the table, locate the horizontal row containing the ICD-O topography codes for each site being checked. If they are in the SAME horizontal row, they are considered the same site, whether the first three characters are the same or different. If they are in DIFFERENT horizontal rows, they are considered to be different sites, whether the first three characters are the same or different.

   When determining multiple primaries using this table, both invasive and in situ cancers are to be considered.

   Examples: The base of the tongue (C01.9) and the border of the tongue (C02.1) are located in the same horizontal row in the table. They are considered subsites of the tongue and, therefore, would be treated as one primary. If it is a single lesion that overlaps both sites, refer to Table 17 on page 25 of ICD-O-3 and code to C02.8. If there are multiple, independent tumors in both sites, code to C02.9.

   An invasive urothelial cell carcinoma of the renal pelvis (C65.9) and an in situ urothelial cell carcinoma of the mid-ureter (C66.9) would be considered one primary in the urinary system, as they are located in the same horizontal row. If these are independent, separate lesions, code as instructed using the table on the next page.

   However, an invasive urothelial cell carcinoma of the renal pelvis (C65.9) and an in situ urothelial cell carcinoma of the urinary bladder (C67.__) would be considered different sites (and different primaries), as the urinary bladder does not appear in the same horizontal row as the renal pelvis.

SEER Site Grouping Table

The purpose of the table in this manual is to group sites that are treated as a single site when abstracting a case.

ICD-O-3 Code	Site Groupings	Code To
C01 C02	Base of tongue Other and unspecified parts of tongue	C029 Tongue, NOS
C05 C06	Palate Other and unspecified parts of mouth	C069 Mouth, NOS
C07 C08	Parotid gland Other and unspecified major salivary glands	C089 Major salivary glands, NOS
C09 C10	Tonsil Oropharynx	C109 Oropharynx, NOS
C12 C13	Pyriform sinus Hypopharynx	C139 Hypopharynx, NOS
C23 C24	Gallbladder Other and unspecified parts of the biliary tract	C249 Biliary tract, NOS
C30 C31	Nasal cavity and middle ear Accessory sinuses	C319 Accessory sinuses, NOS
C33 C34	Trachea Bronchus and lung	C349 Lung, NOS
C37 C380 C381-3 C388	Thymus Heart Mediastinum Overlapping lesion of heart, mediastinum, and pleura	C383 Mediastinum, NOS
C51 C52 C577 C578-9	Vulva Vagina Other specified female genital organs Unspecified female genital organs	C579 Female genital, NOS
C569 C570 C571 C572 C573 C574	Ovary Fallopian tube Broad ligament Round ligament Parametrium Uterine adnexa	Code C569 (ovary) when ovary is one of the involved sites Code C579 (female genital, NOS) when only non-ovarian sites are involved.
C60 C63	Penis Other and unspecified male genital organs	C639 Male genital, NOS
C64 C65 C66 C68	Kidney Renal pelvis Ureter Other and unspecified urinary organs	Code C649 when one of the involved organs is kidney Code C689 (Urinary system, NOS) when only non-kidney sites are involved
C74 C75	Adrenal gland Other endocrine glands and related structures	C759 Endocrine gland, NOS

Note: This table is **not** identical to Table 24 on page 36 in ICD-O-3. Listed in the table in ICD-O-3 is the pleura, C38.4, which has a horizontal row all to itself.

HOW TO DETERMINE SAME VS. DIFFERENT HISTOLOGY (BASED ON ICD-O-3 HISTOLOGY CODES)

1. If the **first three digits of the ICD-O-3 histology codes are the same,** it is the same histology.

   Example: Scirrhous adenocarcinoma (8141) is a more specific type of adenocarcinoma (8140). If a biopsy of a site shows adenocarcinoma and the resected specimen shows scirrhous adenocarcinoma, it is one primary malignancy and is histologically coded to the more specific, scirrhous adenocarcinoma.

   Exception: The ICD-O-3 histology code for non-small cell carcinoma (8046) is a separate morphology group from the small cell histologies (codes 8040 - 8045). Even though the first three digits are the same, they are different histologies.

MULTIPLE PRIMARY RULES FOR SOLID TUMORS

Definitions

Simultaneous tumors are identified at the time of diagnosis.

Synchronous tumors are diagnosed within two months of the original/initial diagnosis.

The multiple primary rules are presented in two formats, text and table. Note that the rule numbers in both formats are identical.

Use the following rules to determine whether to report a single primary or multiple primaries. Coding rules for the data items mentioned such as primary site, histology, laterality, etc. are not described in detail in this section; refer to the instructions for coding each data item elsewhere in this manual.

Rules for Single Tumor

Rule 1: **A single lesion composed of one histologic type is a single primary, even if the lesion crosses site boundaries.**

Example 1: A single lesion involving the tongue and floor of mouth is one primary.

Example 2**:** A single, large mucinous adenocarcinoma involving the sigmoid and descending colon segments is one primary. The pathologist will usually pinpoint the site of origin: "mucinous adenocarcinoma of the sigmoid colon with extension to the descending colon".

Rule 2: A single lesion composed of multiple (different) histologic types is a single primary even if it crosses site boundaries.

The most frequent combinations of histologic types are listed in ICD-O-3. For example, combination terms such as "adenosquamous carcinoma (8560/3)" or "small cell-large cell carcinoma (8045/3)" are included. A single lesion composed of mixed or multiple histologies is a single primary.

Example 1: A single lesion containing both embryonal cell carcinoma and teratoma is a single

primary and would be coded to 9081/3, mixed embryonal carcinoma and teratoma.
***Example 2*:** A single lesion of the liver composed of neuroendocrine carcinoma (8246/3) and hepatocellular carcinoma (8170/3) is a single primary and would be coded to the more specific histology, neuroendocrine carcinoma 8246/3.

Please see "Coding Complex Morphologies" elsewhere in this manual.

Rules for Multiple Tumors

Rule 3a: Simultaneous multiple lesions of the same histologic type within the same site (i.e., multi*focal* tumors in a single organ or site) are a single primary. If one lesion has a behavior code of in situ /2 and the other lesion has a behavior code of malignant /3, this is a single primary whose behavior is malignant /3.

Example 1: At nephrectomy, two separate, distinct foci of renal cell carcinoma are found in the specimen, in addition to the 3.5 cm primary renal cell carcinoma. Abstract as a single primary.

Example 2: At mastectomy for removal of a 2 cm invasive ductal carcinoma, an additional 5 cm area of intraductal carcinoma was noted. Abstract as one invasive primary.

Rule 3b: If a new cancer of the same histology as an earlier one is diagnosed in the same site within two months, this is a single primary cancer.

Example: Adenocarcinoma in adenomatous polyp (8210) in sigmoid colon removed by polypectomy in December 2004. At segmental resection in January 2005, an adenocarcinoma in a tubular adenoma (8210) adjacent to the previous polypectomy site was removed. *Count as one primary.*

Rule 4: If both sides of a paired organ are involved with the same histologic type within two months of the initial diagnosis:

a. It is one primary if the physician states the tumor in one organ is metastatic from the other.
   i. Code the laterality to the side in which the primary originated.
   ii. Code the laterality as 4 if it is unknown which in which side the primary originated.

b. Code as multiple primaries if the physician states these are independent primaries or when there is no physician statement that one is metastatic from the other.

Exception 1: Simultaneous bilateral involvement of the **ovaries** with the same histology is one primary and laterality is coded '4' when it is unknown which ovary was the primary site.

Exception 2: Bilateral **retinoblastomas** are a single primary with laterality of '4'.

Exception 3: Bilateral **Wilms** tumors are always a single primary with laterality of '4.'

Rule 5: If a tumor with the same histology is identified in the same site at least two months after the initial/original diagnosis **(metachronous)**, this is a **separate primary.**

Example 1*:* Infiltrating duct carcinoma of the upper outer quadrant of the right breast diagnosed March 2004 and treated with lumpectomy. Previously unidentified mass in left inner quadrant right breast noted in July 2004 mammogram. This was removed and found to be infiltrating duct carcinoma. Abstract the case as two primaries.

Example 2*:* During the workup for a squamous cell carcinoma of the vocal cord, a second squamous cell carcinoma is discovered in the tonsillar fossa. Abstract as two primaries.

Exception 1**:** This is a single primary only when the physician documents that the initial/original tumor gave rise to the later tumor.

Exception 2: Effective with cases diagnosed January 1995 and later, if an in situ tumor is followed by an invasive cancer in the same site more than two months apart, report as two primaries even if stated to be a recurrence. The invasive primary should be reported with the date of the *invasive* diagnosis. (***Note:*** The purpose of this guideline is to ensure that the case is counted as an incident case (i.e., invasive) when incidence data are analyzed.)

SEER registries must use the COC data item Type of First Recurrence to determine multiple primaries when the first primary is in situ followed by an invasive 'recurrence' (according to COC) that has to be reported to SEER as a new invasive primary. The principal codes that must be reviewed are shown below.

COC Data Item - Type of First Recurrence
If the tumor was originally diagnosed as in situ and the recurrence code is 16, 17, 26, 27, 36, or 46 then the 'recurrence' must be reported as a new case.

16 Local recurrence of an in situ tumor, NOS
17 Both local and trocar recurrence of an in situ tumor.
26 Regional recurrence of an in situ tumor, NOS.
27 Recurrence of an in situ tumor in adjacent tissue or organ(s) and in regional lymph nodes at the same time.
36 Both regional recurrence of an in situ tumor in adjacent tissue or organ(s) and/or regional lymph nodes (26 or 27) and local and/or trocar recurrence (16 or 17).
46 Distant recurrence of an in situ tumor.

Exception 3: Report as a single primary and prepare a single abstract for the first invasive lesion:

- Multiple invasive adenocarcinomas of the prostate (C619)
- Multiple invasive bladder cancers (C670 - C679) with histology codes 8120-8131

Example 1: Urothelial bladder tumor removed by transurethral resection of the bladder (TURB). At three month check-up, a new urothelial tumor is removed. Abstract as one primary of the bladder.

Example 2**:** Patient has elevated PSA and a needle biopsy that shows adenocarcinoma in the right lobe of the prostate. Patient and clinician opt for "watchful waiting." Four months

later, PSA is higher and patient has a second biopsy, which shows adenocarcinoma in the left lobe. Abstract as one primary of the prostate.

Exception 4: Kaposi sarcoma (9140) is reported only once and is coded to the site in which it arises. Code the primary site to skin (C44_) when Kaposi sarcoma arises in skin and another site simultaneously. If no primary site is stated, code the primary site to skin, NOS (C449).

Rule 6: Multiple synchronous lesions of different histologic types within a single paired or unpaired organ are separate primaries.

***Example 1*:** A patient undergoes a partial gastrectomy for adenocarcinoma of the body of the stomach. In the resected specimen, the pathologist finds both adenocarcinoma and nodular non-Hodgkin lymphoma. Abstract two primaries.

Exception 1: Multiple lesions in a single site occurring within two months: if one lesion is carcinoma, NOS, adenocarcinoma, NOS, sarcoma, NOS, or melanoma, NOS and the second lesion is more specific, such as large cell carcinoma, mucinous adenocarcinoma, spindle cell sarcoma, or superficial spreading melanoma, abstract as a single primary and code the histology to the more specific term.

Exception 2: For colon and rectum tumors:

a. When an adenocarcinoma (8140/_; in situ or invasive) arises in the same segment of the colon or rectum as an adenocarcinoma in a polyp (8210/_, 8261/_, 8263/_), abstract a single primary and code the histology as adenocarcinoma (8140/_).
b. Familial adenomatous polyposis (FAP) (8220) with malignancies arising in polyps in the same or multiple segments of the colon or rectum, abstract as a single primary.

Exception 3: There are certain sites in which multiple foci of tumor and multiple histologic types are commonly found together. These multifocal, multi-histologic tumors occur most frequently in the thyroid (papillary and follicular), bladder (papillary and transitional cell) and breast (combinations of ductal and lobular, and combinations of Paget disease and ductal/intraductal). They are abstracted as a single primary with a mixed histology. In such cases, consult ICD-O-3 for a list of the most frequent histologic combinations.

***Example 1**:* A thyroid specimen contains two separate carcinomas - one papillary and the other follicular. Abstract one primary when the histology is papillary and follicular (8340).

Example 2: Abstract one primary when **multiple bladder** tumors are **papillary urothelial** (8130) and/or **transitional** cell (8120).

Example 3: *A* left mastectomy specimen yields lobular carcinoma in the upper inner quadrant and intraductal carcinoma in the lower inner quadrant. Code one primary.

Example 4: A right mastectomy specimen yields Paget in the nipple and a separate underlying ductal carcinoma. Code one primary. Assign the combination code 8543 (Ductal and Paget disease).

Rule 7: Multiple synchronous lesions of different histologic types in paired organs are multiple primaries. If one histologic type is reported in one side of a paired organ and a different histologic type is reported in the other paired organ, these are two primaries unless there is a statement to the contrary.

Example 1: If a ductal tumor occurs in one breast and a lobular tumor occurs in the opposite breast, these are two separate primaries.

Rule 8: Multiple metachronous lesions of different histologic types within a single site are separate primaries.

Rule 9: Multiple lesions of different histologic types occurring in different sites are separate primaries whether occurring simultaneously or at different times.

Example 1: In 1999, the patient had a mucin-producing carcinoma of the transverse colon. In 2002, the patient was diagnosed with an astrocytoma of the frontal lobe of the brain. Abstract as separate primaries.

Example 2: During the workup for a transitional cell carcinoma of the bladder, the patient has a TURP that shows adenocarcinoma of the prostate. Abstract as separate primaries.

Rule 10: Multiple lesions of the same histologic type occurring in different sites are separate primaries unless stated to be metastatic.

Example: A squamous cell carcinoma of the left upper lobe of the lung and a squamous cell carcinoma of the vulva are considered separate primaries unless the physician states that one site is metastatic from the other.

Table of Rules to Determine Multiple Primaries for Solid Tumors

Rule	Tumors	Site(s)	Histology	Variables	Timing	Single vs. multiple primary
1	Single	NA	NA		NA	Single
2	Single	NA	Different		NA	Single
3a	Multiple	Same	Same	Non-paired or only one side of paired organ	Simultaneous or synchronous	Single
3b	Multiple	Same	Same	Non-paired or only one side of paired organ	Simultaneous or synchronous	Single
4	Multiple	Same (bilateral)	Same	Both sides of paired organ involved	Simultaneous or synchronous	Multiple unless physician states one is metastatic. ***Exceptions:*** Bilateral tumors: Ovary (same histology), retinoblastoma, or Wilms tumor are a single primary
5	Multiple	Same	Same		Metachronous	Multiple unless physician states recurrent or metastatic ***Exceptions:*** 1. Report as a **singl**e primary: a. Invasive prostate with histology (8140) b. Invasive bladder with histologies (8120-8130) c. Kaposi sarcoma (9140) 2. For all sites: Report as multiple primaries: In situ followed by invasive **even if stated to be recurrence**.
6	Multiple	Same	Different	Single paired or unpaired organ	Simultaneous or synchronous	Multiple ***Exceptions:*** The following are single primaries: 1. One histology is a more specific histology than the other (NOS and specific). 2. Colon: a. Adeno) carcinoma and (adeno) carcinoma arising in a polyp. b. Familial adenomatous polyposis (FAP) with malignancies arising in polyps. 3. Histology combinations commonly found togeth a. Thyroid (follicular and papillary) b. Bladder (transitional and papillary) 4. Breast: if two lesions in one breast are: a. Lobular and ductal b. Paget disease and ductal or intraductal
7	Multiple	Same	Different	Both sides of paired organ	Simultaneous or synchronous	Multiple ***Exceptions:*** Report as single: 1. If stated to be metastatic
8	Multiple	Same	Different		More than 2 months after original/initial tumor	Multiple
9	Multiple	Different	Different		NA	Multiple
10	Multiple	Different	Same		NA	Multiple unless stated to be metastatic ***Exception:*** Wilms tumor

Multiple Primary Rules for Solid Tumors - Rule Number Conversion Table

This table displays the current Multiple Primary Rules for Solid Tumors by rule number compared to the SEER Program Code Manual 3rd edition rule(s).

Current Rule Number	SPCM 3rd edition Rule Number	Comment
1	1	
2	2	
3a	4a	
3b	3	Former Rule 3 is now two rules: Rule 3b and Rule 5
4a	6a, ii	
4b	6a, i	
4b, exception 1	6a, exception 1	
4b, exception 2	6a, exception 2	Former Rule 6a, exception 2 is now two exceptions: Rule 4b, exception 2 and Rule 4b, exception 3
4b, exception 3	6a, exception 2	Former Rule 6a, exception 2 is now two exceptions: Rule 4b, exception 2 and Rule 4b, exception 3
5	3	Former Rule 3 is now two rules: Rule 3b and Rule 5
5, exception 1	3	
5, exception 2	3, exception 2	
5, exception 3	3, exception 1	
5, exception 4	3, exception 3	
6	5a	
6, exception 1	5, exception 1	
6, exception 2, a	5, exception 1, i and ii	
6, exception 2, b		
7	6b	
8	5a	
9	5b	
10	4b	

DETERMINING MULTIPLE PRIMARIES				
Lesions	**Site (s)**	**Histology**	**Variables**	**Primary**
Single	Single	Single		Single
	Single	Mixed/multiple		Single
	Single	Single	Simultaneous	Single
Single or Multiple	Single	Single	Different behavior codes, in situ (2) and invasive (3)	Single
	Same as previous site	Same as previous histology	Within two months of diagnosis	Recurrence of the original primary
	Same as previous site	Same as previous histology	More than two months after diagnosis	New primary unless physician states it is metastatic **Exceptions:** Basal squamous, basosquamous cell carcinoma of the skin, bladder, Kaposi's sarcoma, adenocarcinoma of prostate
Multiple	Multiple	Single	Simultaneous	Multiple UNLESS physician states it is metastatic **Exceptions:** Ovaries (simultaneous bilateral), retinoblastoma, and Wilms tumor are single primaries
	Single	Mixed/multiple	Simultaneous	Single
	Single	Multiple (Each tumor has a different histology)	Simultaneous	Multiple **Exceptions:** Breast (lobular and ductal); bladder (transitional and papillary)
	Multiple	Multiple	Simultaneous	Multiple

* See the preceding site and histology rules for definition of "multiple".

DETERMINING MULTIPLE PRIMARIES: HEMATOPOIETIC PRIMARIES (Lymphoma and Leukemia) FOR CASES DIAGNOSED ON OR AFTER JANUARY 1, 2001

Rules for Determining Multiple Primaries Based on ICD-O-3 Reportable Hematopoietic Neoplasms for Cases Diagnosed January 1, 2001 and After

A table based on ICD-O-3 reportable malignancies can be found in Appendix H. This table is effective with diagnosis January 1, 2001 and after. To use the table, assign the ICD-O-3 code to the first diagnosis and find the row containing that code. Assign the ICD-O-3 code for the second diagnosis and find the row containing that code. In the cell at the intersection of the first diagnosis row and the second diagnosis column, an S symbol indicates that the two diagnosis are most likely the same disease process (prepare a single abstract) and a D indicates they are different disease process (prepare more than one abstract).

If the physician clearly states that a hematopoietic diagnosis is a new primary, use that information. If there is no clear information from the physician, use the SEER table "Definitions of Single and Subsequent Primaries for Hematologic Malignancies" to determine multiple primaries. Refer to Appendix H to view this table.

Exception: As per ICD-O-3 Errata and Clarifications dated May 22, 2001: "The WHO Classification lists B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma (BCCLL/SLL) as a single entity, the same disease at different stages. The topographic or primary site code for a diagnosis such as BCCLL/SLL depends on where the disease is diagnosed: if disease is diagnosed only in the blood or bone marrow, code the primary site to C42.1, bone marrow, and assign the leukemia morphology code. If the diagnosis is made on any other tissue (typically lymph nodes, lymphatic structures, breast, and stomach), code to the tissue involved and assign the lymphoma morphology. If the diagnosis is made on both blood or bone marrow and a tissue biopsy, code the tissue involved and assign the lymphoma morphology. The sequence of the biopsies (whether the blood/bone marrow biopsy is done before the tissue biopsy or vice versa) is not a factor in deciding which primary site and morphology code to use."

DETERMINING MULTIPLE PRIMARIES: HEMATOPOIETIC PRIMARIES (Lymphoma and Leukemia) FOR CASES DIAGNOSED BEFORE JANUARY 1, 2001

The table in Appendix N is to be used to help determine multiple primaries of the lymphatic and hematopoietic diseases diagnosed prior to January 2001 and is taken from ROADS (Registry Operations and Data Standards), Volume II, published by the American College of Surgeons' Commission on Cancer.

To use the table, locate the first diagnosis in the left column of the table, then locate the second diagnosis in the other columns. If the second primary appears in the middle column, the two diagnoses are usually considered two separate primaries. If the second diagnosis appears in the right-hand column, then the two diagnoses are usually considered one primary. Select the disease mentioned in the first column unless there is an indication in the right-hand column to do otherwise. If the pathology report specifically states differently, use the pathology report. Consult your medical advisor or pathologist if questions remain.

> ***Example 1:*** First diagnosis: small cleaved cell, diffuse lymphoma (9672); second diagnosis, Hodgkin's disease, mixed cellularity (9652). According to the table, this case would be considered two primaries.
>
> ***Example 2:*** First diagnosis, small cleaved cell, diffuse lymphoma (9672); second diagnosis: acute lymphocytic leukemia (9821 or 9828). According to the table, this would be considered one primary.

DETERMINING MULTIPLE PRIMARIES: BENIGN AND BORDERLINE PRIMARY INTRACRANIAL AND CNS TUMORS (C70.0-C72.9, C75.1-C75.3)

Definitions

Same site: The first two numeric digits of the ICD-O-3 topography code are identical.

Different site: The first two numeric digits of the ICD-O-3 topography code are different.

Timing: The amount of time between the original and subsequent tumors is not used to determine multiple primaries because the natural biology of non-malignant tumors is that of expansive, localized growth.

HOW TO DETERMINE SAME VS DIFFERENT HISTOLOGIES (BASED ON HISTOLOGIC GROUPINGS)

When there are **multiple tumors**, use the following table to determine if the tumors are the same histology or different histologies.

Histologic groupings to determine same histology for non-malignant brain tumors

Histologic Group	ICD-O-3 Code
Choroid plexus neoplasms	9390/0, 9390/1
Ependymomas	9383, 9394, 9444
Neuronal and neuronal-glial neoplasms	9384, 9412, 9413, 9442, 9505/1, 9506
Neurofibromas	9540/0, 9540/1, 9541, 9550, 9560/0
Neurinomatosis	9560/1
Neurothekeoma	9562
Neuroma	9570
Perineurioma, NOS	9571/0

Instructions for Using Histologic Group Table

1. **Both** histologies are listed **in** the **table**

    a. Histologies that are in the same **grouping** or row in the table are the **same histology**.
    b. ***Note:*** Histologies that are in the same grouping are a progression, differentiation or subtype of a single histologic category.
    c. Histologies listed in **different groupings** in the table are **different histologies**.

2. One or both of the **histologies** is **not** listed **in** the **table**

    a. If the **ICD-O-3 codes** for both histologies have the **identical** first three digits, the histologies are the **same**.
    b. If the first three digits of the **ICD-O-3** histology code are **different**, the histology types are different.

MULTIPLE PRIMARY RULES FOR BENIGN AND BORDERLINE PRIMARY INTRACRANIAL AND CNS TUMORS

The multiple primary rules are presented in two formats, text and table. Note that the rule numbers in both formats are identical.

Use the following rules to determine whether to report a single primary or multiple primaries. Coding rules for the data items mentioned such as primary site, histology, laterality, etc. are not described in detail here; refer to the instructions for coding each data item.

Note: If there is a **single tumor**, it is always a **single** primary

Rule 1: Multiple non-malignant tumors of the **same histology** that recur in the **same site** and **same side** (laterality) as the original tumor are recurrences (single primary) even after 20 years.

Rule 2: Multiple non-malignant tumors of the **same histology** that recur in the **same site** and it is unknown if it is the same side (laterality) as the original tumor are recurrences (single primary) even after 20 years.

Rule 3: Multiple non-malignant tumors of the same histology in **different sites** of the CNS are separate (multiple) primaries.

Rule 4: Multiple non-malignant tumors of the same histology in **different sides** (laterality) of the CNS are separate (multiple) primaries.

Rule 5: Multiple non-malignant tumors of different histologies are separate (multiple) primaries.

Table of Rules to Determine Multiple Primaries for Benign and Borderline Primary Intracranial and CNS Tumors

Rule #	Site	Laterality	Histology	Primary(ies)
1	Same	Same	Same	Single
2	Same	Unknown	Same	Single
3	Different	Any	Same	Multiple
4	Same	Different sides of the same site in the CNS	Same	Multiple
5	Any	Any	Different	Multiple

Morphology

The *International Classification of Diseases for Oncology, Third Edition (ICD-O-3)* is used for coding the morphology of all cancers diagnosed on or after January 1, 2001. The *Second Edition* is used for coding morphology of all cancers diagnosed after January 1, 1992 and before January 1, 2001 and the *First Edition* was used for cases diagnosed after January 1, 1976 and before January 1, 1992. Classifications for all neoplasms have been reviewed and updated in the Third Edition of ICD-O but the most extensive revision concerned hematologic malignancies. In the Alphabetic Index all morphology codes are indicated by an M- preceding the code number. The M- should not be coded.

Morphology is a 6-digit code consisting of three parts:

A Histologic type (4 digits)
B Behavior code (1 digit)
C Grading or differentiation; or for lymphomas and leukemias, designation of T-cell, B-cell, null cell, or NK cell (1 digit)

The morphology of a tumor can be coded only after the determination of multiple primaries has been completed.

To code morphology (histology, behavior and grade), use the best information from the entire pathology report (microscopic description, final diagnosis, comments).

General Rule

If the final diagnosis gives a specific histology, code it. Similarly, if grade is specified in the final diagnosis, code it. Exceptions are found on the following pages under "Histologic Type", "Behavior Code", and "Grade, Differentiation, or Cell Indicator".

Histologic Type

The morphology can be coded only after the determination of multiple primaries has been completed. In coding histologic type, usually the FINAL pathologic diagnosis is coded. All pathology reports for the primary under consideration should be used. Although the report from the most representative tissue is usually the best, sometimes all of the cancerous tissue may be removed at biopsy and; therefore, the report from the biopsy must be used.

If a definitive statement of a more specific histologic type is found in the microscopic description or in the comment, the more specific histologic diagnosis should be coded.

Code the histology using the following rules:

Single lesion - same behavior

1. Code the histologic type using the following rules in sequence:

1A. Use a combination code if one exists:
8255/3 Renal cell carcinoma, mixed clear cell and chromophobe types
8523/3 Infiltrating duct carcinoma, mixed with other types of carcinoma
8524/3 Infiltrating lobular carcinoma mixed with other types of carcinoma

1B. Use the more specific term if one is an "NOS" term (carcinoma) and the other term is more specific:
"Adenocarcinoma (8140/3) of the sigmoid colon, predominantly mucin-producing." *Code to mucin-producing adenocarcinoma (8481/3).*

"Invasive carcinoma, probably squamous cell type." *Code to squamous cell carcinoma (8070/3) since it is more specific than carcinoma (8010/3).*

"Adenocarcinoma of prostate, with cribriform differentiation." *Code cribriform carcinoma (8201/3) since it is more specific than adenocarcinoma.*

1C. The majority of the tumor if Rule 1A or Rule 1B above cannot be used.

Terms that indicate a majority of tumor	Terms that do not indicate a majority of tumor
predominantly...	...with foci of.
with features of...	...focus of/focal
major	...areas of
type*	...elements of..
with...differentiation	...component

* "Type" can be a different cell, a variant of the same cell, or a subset of a more generic term. In most cases, mixed =combined. Sometimes, "mixed" indicates a unique tumor, not a combination. Ignore terms that do not indicate a majority of tumor. When both terms are specific (in other words, not NOS) and no combination code exists, code the majority of the tumor.

Example of majority tumors:
"Predominantly leiomyosarcoma associated with foci of well-developed chondrosarcoma." *Code the majority tumor - leiomyosarcoma (8890/3).*

2. Histologies with the same behavior code are coded to the higher histology code in ICD-O-3 unless a combination histology code is available. Rule 1 takes precedence over rule 2.

Example: Pleural tumor containing malignant mesothelioma (9050/3) and neuroendocrine carcinoma (8246/3) would be coded to malignant mesothelioma (9050/3) as no combination code exists for these two histologies.

Single lesion - different behaviors

1. Histologies with different behavior codes are coded to the histology associated with the malignant behavior.

Example: Squamous cell carcinoma in situ (8070/2) and papillary squamous cell carcinoma (8052/3) would be coded papillary squamous cell carcinoma (8052/3).

Exception: If the histology of the invasive component is an >NOS= term (e.g., carcinoma, adenocarcinoma, melanoma, sarcoma), then use the specific term associated with the in situ component and an invasive behavior code.

Example of exception: Squamous cell carcinoma in situ (8070/2) with areas of invasive carcinoma (8010/3) would be coded squamous cell carcinoma (8070/3).

Multiple lesions - considered a single primary

1. If one lesion is stated to be an "NOS" term (e.g., carcinoma, adenocarcinoma, melanoma, sarcoma) and the second lesion is an associated but more specific term (e.g., large cell carcinoma, mucinous adenocarcinoma, spindle cell sarcoma, respectively), code to the more specific term.

2. For colon and rectum primaries:

   When an adenocarcinoma (8140/_; in situ or invasive) arises in the same segment of the colon or rectum as an adenocarcinoma in a polyp (8210/_, 8261/_, 8263/_), code as adenocarcinoma (8140/_).

   When a carcinoma (8010/_; in situ or invasive) arises in the same segment of the colon or rectum as a carcinoma in a polyp (8210), code as carcinoma (8010/_).

3. If the histologies of multiple lesions can be represented by a combination code, use that code.

CODING COMPLEX BREAST HISTOLOGIES

The following is taken directly from "Coding Complex Morphologies", prepared by SEER.

Apply these guidelines in priority order. Use the first guideline that applies.

Single Tumors with Complex Histology

1. If the diagnosis is both lobular and ductal (in situ or invasive or a combination), use code 8522.
   Examples: Duct carcinoma and lobular carcinoma in situ - code as 8522/3.
   LCIS and DCIS - code as 8522/2.

2. If the diagnosis is mixed invasive and in situ, code the invasive diagnosis.
   Examples: Ductal carcinoma with extensive cribriforming DCIS - code as 8500/3
   Mucinous carcinoma in a background of ductal carcinoma in situ - code as 8480/3
   Infiltrating ductal carcinoma with DCIS, solid, cribriform and comedo type - code as ductal carcinoma, 8500/3.

3. Use a combination code if the diagnosis is duct carcinoma or lobular carcinoma mixed with another type of carcinoma.
   Look for "and" or "mixed" in the diagnosis.
   a. If the diagnosis is duct carcinoma mixed with another type of carcinoma (excluding lobular), use code 8523/_.
      Examples: Duct carcinoma **and** tubular carcinoma - code as 8523/3.
      DCIS and cribriform carcinoma in situ - code as 8523/2
   b. If the diagnosis is lobular carcinoma mixed with another type of carcinoma (excluding ductal), use code 8524.
      Examples: Lobular and adenoid cystic carcinoma - code as 8524/3
      Tubular carcinoma and lobular carcinoma - code as 8524/3

4. Code the specific type if the diagnosis is
   · Duct carcinoma, _____ type
   · Duct carcinoma, predominantly _____
   · Duct carcinoma with features of _____
   Code the stated type (subtype) even if the code is lower than 8500.
   Look for the term "type," "subtype," or "variant" or terms that indicate the majority of the tumor.
   Examples: Duct carcinoma, tubular type - code as tubular carcinoma, 8211
   Duct carcinoma with apocrine features - code as apocrine carcinoma, 8401/3

5. If the diagnosis includes more than one subtype, use a combination code.
   Examples: Duct carcinoma, cribriform and comedo types - code as 8523/3.
   Duct carcinoma in situ, showing both solid and cribriforming subtypes - code as 8523/2

Separate Tumors of Different Histologies in One Breast

6. If different histologies occur in separate tumors in the same breast, use a combination code if possible and count the case as a single primary.
   Examples: LCIS UIQ right breast and duct carcinoma LIQ - code as 8522/3
   Paget disease of nipple and intraductal carcinoma, UOQ - code as 8543/3

HISTOLOGY CODES FOR INVASIVE BREAST CANCERS

Histology code must reflect the invasive tumor; terms include invasion, infiltrating, infiltration

I. Invasive only, single type, no in situ component		
Invasive carcinoma	8010/3	
Invasive adenocarcinoma	8140/3	
Invasive ductal (duct) carcinoma	8500/3	
Invasive lobular carcinoma (NOS and subtypes)	8520/3	
Tubular carcinoma	8211/3	
Mucinous (colloid) carcinoma	8480/3	
Medullary carcinoma	8510/3	
Adenoid cystic carcinoma	8200/3	
Intraductal papillary carcinoma with invasion		8503/3
Apocrine adenocarcinoma	8401/3	
Metaplastic carcinoma	8575/3	
Other rare types		
Paget disease (rare without underlying carcinoma, which is usually invasive, but may be DCIS only)	8540/3	
II. Invasive only, 2 or more types, no in situ component		
Invasive ductal and lobular	8522/3	
Invasive ductal and mucinous (colloid)	8523/3	
Invasive ductal and tubular	8523/3	
Invasive ductal and cribriform (cribriform also invasive)	8523/3	
Invasive lobular and other types (except ductal)	8524/3	
III. Invasive, one type, with DCIS or/and LCIS present		
Invasive ductal and DCIS (loses the DCIS)	8500/3	
Invasive lobular and DCIS	8522/3	
Invasive ductal and LCIS	8522/3	
Invasive lobular and LCIS (loses the LCIS)	8520/3	
IV. Invasive, 2 or more types, with DCIS or/and LCIS		
Code as in category II; the CIS will be lost		

HISTOLOGY CODES FOR NON-INVASIVE BREAST CANCERS

No invasion present (DCIS and/or LCIS only)

I. Intraductal (ductal carcinoma in situ, DCIS) only	8500/2
II. Intraductal, with one subtype specified	
DCIS papillary (intraductal papillary)	8503/2
DCIS micropapillary or clinging	8507/2
DCIS cribriform	8201/2
DCIS solid	8230/2
DCIS comedo	8501/2
III. Intraductal, with two or more subtypes specified	523/2
IV. Intralobular (lobular carcinoma in situ, LCIS)	8520/2
V. Both DCIS and LCIS (any DCIS subtypes will be lost)	8522/2

Examples of Complex Breast Diagnoses (coded, with comments)

Assume these examples are single primaries.

8401/3 Core needle breast bx: PD infiltrating ductal carcinoma with aprocrine subtype of ductal ca.
Code the stated subtype of the invasive component.

8500/3 FNA L breast mass, UIQ: Atypical hyperplasia with clusters suspicious for carcinoma.
Needle localization (L breast, UOQ) followed by exc bx: Scirrhous ductal carcinoma and DCIS (comedo pattern); TS = 1.8 x 2.0 x 2.0 cm; extensive cribriforming noted. Margins of resection are clean.
Code the invasive component. "Scirrhous" is an adjective meaning "hard" Although it has a code in ICD-O-3, ductal carcinoma is the more precise term. According to our medical advisor, ignore "scirrhous" when it is used in combination with another histologic descriptor. If the term is "scirrhous carcinoma," code as 8141/3.

8507/3 Infiltrating ductal ca; focal micropapillary invasive pattern and intralymphatic tumor are additional features.
Use the "micropapillary invasive" information to code the more specific term.

8520/3 Infiltrating lobular ca, pleomorphic variant, measuring 5.4 cm.
A pleomorphic variant (subtype) of lobular carcinoma is not the same as pleomorphic carcinoma. Code as lobular carcinoma, NOS.

8522/2 Right breast lumpectomy specimen: Extensive in situ carcinoma with mixed ductal and lobular features and the following characteristics: 1) Two foci suspicious but not definitive for invasion. 2) Solid and cribriform histologic patterns.
Use the guidelines in order. Code the ductal and lobular combination. For coding purposes, any ductal carcinoma subtype should be treated as ductal carcinoma when seen in combination with lobular carcinoma or LCIS.

8522/2 Excision bx right breast: Ductal carcinoma in situ with the following characteristics:
1) cribriform and solid subtype. 2) lobular carcinoma in situ.
Use the guidelines in order. Code the ductal and lobular combination.

8522/2 Left breast core needle bx: ductal carcinoma in situ with the following features:
1) Histologic type: cribriform and solid.
Excisional bx:
1) Lobular carcinoma in situ.
2) Rare microscopic foci of ductal carcinoma in situ with the following features:
a) Histologic type: cribriform.
3) Microcalcifications associated with DCIS and LCIS.
Use the guidelines in order. Code the ductal and lobular combination.

8522/2 Stereotactic breast bx: DCIS with the following features:
Pattern: cribriform and solid.
Excision bx: residual ductal carcinoma in situ with the following features:
Histologic type: Solid and cribriform types.
Medial margin: Rare foci reaching minimal criteria for lobular carcinoma in situ. Negative for invasive ca.
Code as ductal and lobular.

Examples of Complex Breast Diagnoses (coded, with comments), continued

8522/3 Infiltrating duct ca with focal lobular features and focal mucinous features. There is cribriform DCIS with focal comedonecrosis adjacent to the infiltrating component.
Use a combination code for the invasive component. Use the first guideline and code the lobular and ductal combination.

8522/3 Right breast excisional biopsy: infiltrating ductal carcinoma with areas of metaplastic carcinoma with associated DCIS, cribriform histologic type and multiple foci of lobular carcinoma in situ.
Code the combination of invasive ductal and lobular in situ. "With areas of" does not constitute a majority of tumor.

8522/3 Left breast mass excision:
1) Infiltrating carcinoma with the following features:
Histologic type: infiltrating ductal carcinoma of apocrine type.
2) Ductal carcinoma in situ with the following features:
1) Histologic type: Apocrine cell type with papillary and solid architecture.
2) Scattered foci of lobular carcinoma in situ.
Use the combination of ductal and lobular.

8522/3 Ductal and papillary carcinoma with separate foci of lobular ca
Code ductal and lobular combination.

8522/3 Ductal ca, mucinous type, and LCIS.
Use the guidelines in order. Use the combination code of ductal and lobular.

8523/3 Mammogun bxs, R breast, 6 specimens:
Specimen #1, UIQ: Ductal carcinoma, in situ, cribriforming type, BR Score 3
Specimen #2, UOQ: NED
Specimen #3, LIQ: Infiltrating papillary ductal carcinoma, well differentiated
Specimen #4, LOQ: NED
Specimen #5: Central breast: NED
Specimen #6: Nipple complex: NED, flaky nipple observation on physical examination is negative for Paget's disease.
R MRM w/R axill LN dissect: Ductal carcinoma, in situ and infiltrating, cribriform and papillary features observed; BR Score 3 to 4. 16 of 23 R axillary LNs with papillary ductal carcinoma present.
Use a combination code to include the cribriform and papillary features.

8523/2 Exc bx, R breast, UOQ: DCIS, cribriform (comedocarcinoma) and micropapillary, nuclear gr. 3.
Codes as multiple subtypes of DCIS.

8523/2 Stereotactic bx left breast: cribriform ductal carcinoma in situ.
Excisional bx: residual ductal carcinoma in situ, solid type.
Use information from both procedures. Code as multiple subtypes of DCIS.

USEFUL COMBINATION CODES

8522/3	Infiltrating duct and lobular carcinoma
8523/3	Infiltrating duct mixed with other types of carcinoma
8524/3	Infiltrating lobular mixed with other types of carcinoma
8542/3	Paget disease and infiltrating duct carcinoma
8543/3	Paget disease and intraductal carcinoma

OTHER COMPLEX MORPHOLOGIC CODES

8255/3 Adenocarcinoma with mixed subtypes

Adenocarcinoma combined with other types of carcinoma

8323/3 Mixed cell adenocarcinoma

THE PROBLEMS

- Terms are not site-specific
- The usual key words we look for can be used for both diagnoses
- Only a pathologist would know the subtle difference between them

UNTIL WE GET FURTHER GUIDANCE ON THESE TWO HISTOLOGIES:

1. Code mixed cell GYN carcinomas and mixed pancreatic islet cell carcinomas (very rare) to 8323.
2. Code mixed tumors of all other sites to 8255 unless there is a better complex code available elsewhere.

GYN Cancers of Mixed Cell Types

Example: Mixed cell adenocarcinoma of ovary can be any combination of
8441 Serous adenocarcinoma
8480 Mucinous adenocarcinoma
8380 Endometrioid adenocarcinoma
8070 Squamous cell carcinoma
9000 Brenner tumor

If more than one mentioned in path report, code to 8323/3 Mixed cell adenocarcinoma.

Renal Cell Carcinoma Subtypes

Renal cell carcinoma (NOS, including hypernephroma [obs])	8312/3
Clear cell	8310/3
Papillary (also called chromophil)	8260/3
Chromophobe	8317/3
Sarcomatoid (spindle cell)	8318/3
Granular cell	8320/3
Collecting duct carcinoma	8319/3

Renal oncocytoma	8290/0
Cyst-associated renal cell carcinoma	8316/3

If more than one mentioned in path report, code to 8255/3 Adenocarcinoma with mixed subtypes.

EXAMPLES OF COMPLEX HISTOLOGIES:

8255/3 Sigmoid: adenocarcinoma with focal mucinous and clear cell differentiation
8255/3 Renal cell ca, mixed clear cell and chromophobe
8255/3 Renal cell ca with mixed granular cell, clear cell, and collecting duct differentiation
8255/3 Renal cell ca, mixed granular cell and clear cell
8255/3 Lung: adenocarcinoma, mixed acinar and papillary type
8045/3 Lung: mixed carcinoma with poorly differentiated and small cell neuroendocrine carcinoma
8323/3 Endometrium: adenocarcinoma with clear cell, papillary and squamous differentiation
8323/3 Pancreas: mixed alpha cell and beta cell carcinomas

8045/3 COMBINED SMALL CELL AND NON-SMALL CELL CARCINOMA

For single tumors, code 8045/3 should be used for combinations or mixtures of small cell (oat cell) carcinoma and any other type of carcinoma (sometimes referred to as "non-small cell" carcinomas). Combinations containing small cell carcinoma and carcinoids, lymphomas, and sarcomas of the lung cannot be coded as 8045/3. For analysis purposes, 8045/3 is included with small cell carcinomas. There are several synonyms and other names for small cell carcinoma, and many different types of carcinomas and adenocarcinomas other than small cell that may be seen in combination with small cell carcinoma in a single tumor.

See Appendix L for a list of terms that mean small cell and a list of 'other than small cell' terms that should be coded to 8045/3 when combined with small cell carcinoma and diagnosed in a single tumor.

MIXED GERM CELL TUMORS

- 9081 Mixed embryonal carcinoma and teratoma
- 9085 Mixed germ cell
  - *usually seminoma and something else*
- 9101 Choriocarcinoma with other germ cell elements
- 9065 Germ cell tumor, nonseminomatous

CHOOSING A CODE FOR A MIXED GERM CELL TUMOR

1. Identify the histologies and note which ones are present.
2. Common germ cell tumors in order of prognosis
   Non-seminoma (9070-9084, 9100)
   Choriocarcinoma 9100
   Yolk sac tumor 9071
   Embryonal cell 9070
   Teratoma 9080
   Seminoma (9061-9064)

3. If one of the cell types is
   choriocarcinoma, use 9101
   embryonal cell, check 9081
   teratoma, check 9081
   seminoma and the other(s) non-seminoma, use 9085
4 If NONE of the germ cell types is seminoma, use 9065

CODING TO THE HIGHER MORPHOLOGY CODE

When a complex morphology code is not available and there is no NOS-specific combination and there is no clear majority of one cell type, code the numerically higher ICD-O-3 code.

Use the higher morphology code when

- the mixed tumor is glandular (adeno) carcinoma and something else (epithelial carcinoma, sarcoma, melanoma, etc.) and there is no combination code

  Examples: Mixed transitional cell carcinoma and squamous cell carcinoma. *Code to higher code, 8120/3.*
  Poorly-differentiated carcinoma with squamous and neuroendocrine differentiation. *Code to higher code, 8246/3.*
  Oral mucosa: carcinoma with trabecular and acinar pattern. *Code to higher code, 8550/3.*

A listing of combined and mixed histology codes is in Appendix L.

BEHAVIOR CODE

The behavior code is recorded in the fifth-digit of the morphology field. The NJSCR requires collection of tumors that have behavior codes of 2, 3 and, in some instances, 1 (borderline reportable). Refer to your NJSCR reportable list in Appendix E for further explanation. Tumors that have behavior codes of 6 (metastatic site) and 9 are not used; rather, they are coded as 3. Refer to the International Classification of Diseases for Oncology, Third Edition, for additional instructions in assigning behavior codes.

Synonymous terms for in situ (behavior code "2") are:

Bowen's disease
melanoma (limited to epithelium)
confined to epithelium
Hutchinson’s melanotic freckle, NOS
intracystic non-infiltrating
intraductal
intraepidermal, NOS
intraepithelial, NOS
involvement up to but not including the basement membrane
lentigo maligna
lobular neoplasia

Synonymous terms for in situ (behavior code "2") (continued)

lobular, noninfiltrating
noninfiltrating
noninvasive
no stromal invasion
papillary, noninfiltrating or intraductal
precancerous melanosis
Queyrat’s erythroplasia
VAIN III
VIN III
AIN

GRADE, DIFFERENTIATION OR CELL INDICATOR

Grade, Differentiation (Codes 1, 2, 3, 4, 9)
Pathologic testing determines the grade, or degree of differentiation, of the tumor. For cancers, the grade is a measurement of how closely the tumor cells resemble the parent tissue (organ of origin). Well-differentiated tumor cells closely resemble the tissue from the organ of origin. Poorly-differentiated and undifferentiated tumor cells are disorganized and abnormal looking; they bear little or no resemblance to the tissue from the organ of origin.

Pathologists describe the tumor grade by levels of similarity. Pathologists may define the tumor by describing two levels of similarity (two-grade system which may be used for colon); by describing three levels of similarity (three-grade system); or by describing four levels of similarity (four-grade system). The four-grade system describes the tumor as grade I, grade II, grade III, and grade IV (also called well-differentiated, moderately- differentiated, poorly-differentiated, and undifferentiated/anaplastic). These similarities/differences may be based on pattern (architecture), cytology, or nuclear features or a combination of these elements depending upon the grading system that is used. The information from this data item is useful for determining prognosis.

Cell Indicator (Codes 5, 6, 7, 8, 9)
Describes the lineage or phenotype of the cell that became malignant. Cell indicator codes apply to lymphomas and leukemias and for these diagnoses, cell indicator takes precedence over grade/differentiation.

See the ICD-O-3 chapter *Morphology* for further instructions on coding grade.

Codes

1 Grade I; grade i; grade 1; well-differentiated; differentiated, NOS
2 Grade II; grade ii; grade 2; moderately-differentiated; moderately well-differentiated; intermediate differentiation
3 Grade III; grade iii, grade 3; poorly-differentiated; dedifferentiated
4 Grade IV; grade iv; grade 4; undifferentiated; anaplastic
5 T-cell; T-precursor
6 B-Cell; Pre-B; B-precursor
7 Null cell; Non T-non B
8 NK cell (natural killer cell) (effective with diagnosis 1/1/1995 and after)
9 Grade/differentiations unknown, not stated, or not applicable

General Coding Rules

1. The site-specific coding guidelines in SEER Program Manual 2004's Appendix C also include rules for coding grade for the following primary sites: prostate, kidney, lymphoma, leukemia, astrocytoma, and sarcoma.

2. Code the grade from the final diagnosis in the pathology report. If there is more than one path report, and the grades in the final diagnoses differ, code the highest grade for the primary site from any pathology report.

3. If grade is not stated in the final pathology diagnosis, use the information in the microscopic section, addendum, or comment to code grade.

4. If more than one grade is recorded for a single tumor, code the highest grade, even if it is a focus.

   Example: Pathology report reads: Grade II adenocarcinoma with a focus of undifferentiated adenocarcinoma. Code the tumor grade as grade 4.

5. Code the grade from the **primary tumor** only, never from a metastatic site or a recurrence.

6. Code the grade for all **unknown primaries** to 9 (unknown grade) unless grade is explicit by histology (i.e. anaplastic carcinoma (grade = 4).

7. Code the grade of the invasive component when the tumor has **both in situ** and **invasive** portions. If the **invasive** component **grade** is **unknown**, code the grade as unknown (9).

8. Code the information from the **consult** if the specimen is sent to a specialty pathology department for a consult.

9. If there are **multiple pathology consults**, ask the pathologist or physician advisor to determine which information should be used.

10. Do **not code** the grade assigned to **dysplasia**, i.e.: High grade dysplasia (adenocarcinoma in situ) would be coded to 9 (unknown grade).

Coding Grade for Cases without Pathology or Cytology Confirmation

Code the grade of tumor given on a Magnetic Resonance Imaging (MRI) or Positron Emission Tomography (PET) report if there is no tissue diagnosis (pathology or cytology report). Use the MRI or PET grade only when there is no tissue diagnosis.

In situ Tumors

In situ tumors are not always graded. Code the grade if it is specified for an in situ lesion unless there is an invasive component. Do not code the in situ grade if the tumor has both in situ and invasive components.

Terminology Conversion Table

Description	Grade	SEER Code
Differentiated, NOS	I	1
Well-differentiated	I	1
Fairly well-differentiated	II	2
Intermediate differentiation	II	2
Low grade	I-II	2
Mid-differentiated	II	2
Moderately-differentiated	II	2
Moderately well-differentiated	II	2
Partially-differentiated	II	2
Partially well-differentiated	I-II	2
Relatively or generally well-differentiated	II	2
Medium grade, intermediate grade	II-III	3
Moderately poorly-differentiated	III	3
Moderately-undifferentiated	III	3
Pleomorphic	III	3
Poorly-differentiated	III	3
Relatively poorly-differentiated	III	3
Relatively-undifferentiated	III	3
Slightly-differentiated	III	3
Dedifferentiated	III	3
High grade	III-IV	4
Undifferentiated, anaplastic, not differentiated	IV	4
Non-high grade		9

Two-Grade System

Some cancers are graded using a two-grade system, for an example, colon cancer. If the grade is listed as 1/2 or as low grade, assign code 2. If the grade is listed as 2/2 or as high grade, assign code 4.

Two-Grade Conversion Table

Grade	Differentiation / Description	SEER Code
1/2, I/II	Low grade	2
2/2, II/II	High grade	4

Three-Grade System

There are several sites for which a three-grade system is used, such as peritoneum, endometrium, fallopian tube, prostate, bladder and soft tissue sarcoma. The patterns of cell growth are measured on a scale of 1, 2, and 3 (also referred to as low, medium, and high grade). This system measures the proportion of cancer cells that are growing and making new cells and how closely they resemble the cells of the host tissue. Thus, it is similar to a four-grade system, but simply divides the spectrum into 3 rather than 4 categories (see Three-Grade Conversion Table below). The expected outcome is more favorable for lower grades.

If a grade is written as 2/3 that means this is a grade 2 of a three-grade system. Do not simply code the numerator. Use the following table to convert the grade to SEER codes:

Three-Grade Conversion Table

Grade	Differentiation / Description	SEER Code
1/3, I/III	Low grade	2
2/3, II/III	Intermediate grade	3
3/3, III/III	High grade	4

Please use the instructions below and on the following page for breast cancer grade coding.

Priority Order for Coding Breast Cancer Grade
Code grade in the following priority order:

1. Bloom-Richardson scores 3-9 converted to grade (See following table)
2. Bloom Richardson grade (low, intermediate, high)
3. Nuclear grade only
4. Terminology
   a. Differentiation (well-differentiated, moderately-differentiated, etc).
5. Histologic grade
   a. Grade 1/I/i, grade 2/II/ii, grade 3/III/iii, grade 4/IV/iv

Breast Grading Conversion Table

BR Scores	BR Grade	Nuclear Grade	Terminology	Histologic Grade	SEER Code
3-5	Low	1/3; 1/2	Well-differentiated	I/III; 1/3	1
6, 7	Intermediate	2/3	Moderately-differentiated	II/III; 2/3	2
8, 9	High	2/2; 3/3	Poorly-differentiated	III/III; 3/3	3

Bloom-Richardson (BR)

1. **BR** may **also** be **called**: modified Bloom-Richardson, Scarff-Bloom-Richardson, SBR grading, BR grading, Elston-Ellis modification of Bloom Richardson score, the Nottingham modification of Bloom Richardson score, Nottingham-Tenovus, or Nottingham grade
2. BR may be expressed in **scores** (range 3-9)
3. The score is based on three morphologic features of "invasive no-special-type" breast cancers (degree of tubule formation/histologic grade, mitotic activity, nuclear pleomorphism of tumor cells).
4. Use the Breast Grading Conversion Table to convert the score, grade or term into the SEER code
5. BR may be expressed as a **grade** (low, intermediate, high)
6. BR grade is derived from the BR score. Note that the conversion of low, intermediate, and high for breast is different from the conversion used for all other tumors.

Kidney Cancer

Priority Order for Coding Kidney Cancer Grade

Code grade in the following priority order:

1. Fuhrman's grade
2. Nuclear grade
3. Terminology (well diff, mod diff)
4. Histologic grade (grade 1, grade 2)

These prioritization rules do not apply to Wilms tumor (8960). Use the general rules for coding grade for Wilms tumor.

Prostate

Priority Rules for Coding Prostate Cancer Grade

Code grade in the following priority order:

1. Gleason's grade (Use the table to convert Gleason's grade information into the appropriate code)

2. Terminology

    a. Differentiation (well differentiated, moderately differentiated, etc.)

3. Histologic grade

    a. Grade 1/I/i, grade 2/II/ii, grade 3/III/iii, grade 4/IV/iv

4. Nuclear grade only

Gleason's Pattern

Prostate cancers are commonly graded using Gleason's score or pattern. Gleason's grading is based on a 5-component system, meaning it is based on 5 histologic patterns. The pathologist will evaluate the primary (majority) and secondary patterns for the tumor. The pattern is written as a range, with the majority pattern appearing first and the secondary pattern as the last number

Example: A Gleason pattern of 2 + 4 means that the primary pattern is 2 and the secondary pattern is 4.

Gleason's Score

The patterns are added together to create a score.

Example*:* If the pattern is 2 + 4, the pattern score is 6 (the sum of 2 and 4).

1. If the pathology report contains only **one number**, and that number is **less than or equal to 5,** it is a pattern.

2. If the pathology report contains only **one number**, and that number is **greater than 5**, it is a score.

3. If the pathology report specifies a specific **number out of a total of 10**, the first number given is the score.

    Example: The pathology report says "Gleason's 3/10". The Gleason's score would be 3.

4. If there are **two numbers other than 10**, assume they refer to two patterns. The first number is the primary pattern and the second is the secondary pattern.

   Example: If the pathology report says "Gleason's 3 + 5," the Gleason's score would be 8, the sum of 3 and 5.

Use the following table to convert Gleason's pattern or score into SEER codes:

Gleason Conversion Table

Gleason's Score	Gleason's Pattern	Histologic Grade	Terminology	SEER Code
2, 3, 4	1, 2	I	Well-differentiated	1
5, 6	3	II	Moderately-differentiated	2
7, 8, 9, 10	4, 5	III	Poorly-differentiated	3

Note: Gleason's score 7 was previously coded to moderately-differentiated (2). Effective with cases diagnosed 1/1/2003, Gleason's score 7 is coded to poorly-differentiated.

Astrocytoma

Grade astrocytomas according to ICD-O-3 rules

1. Do not use the **WHO grade** to code this field.
2. Do not automatically code **glioblastoma multiforme** as grade IV. If no grade is given, code unknown, 9.
3. If **no grade** is given, code unknown, 9.

Lymphoma and Leukemia

1. Do not use the terms “high grade,” “low grade,” and “intermediate grade” to code differentiation. These terms refer to histology, not grade.
2. The designation of T-cell, B-cell, null cell, or NK cell has **precedence** over any statement of differentiation.

    a. Code ANY statement of **T-cell**, **B-cell**, **null cell**, or **NK cell:**

        T-cell (**code 5**)
            Cortical T
            Mature T
            Pre-T
            Pro-T
            T-cell phenotype
            T-precursor
        B-Cell (**code 6**)
            B-cell phenotype
            B-precursor
            Pre-B
            Pre-pre-B
            Pro-B
        Null-Cell; Non-T-non-B (**code 7**)
            Null-cell
            Non T-non-B
            Common cell
        NK (Natural Killer) cell (code 8)
            NK/T cell
        Cell type not determined, not stated or not applicable (code 9)
            Combined B cell and T cell

    b. Use any source to code information on cell type whether or not marker studies are documented in the patient record.

        Example: The history portion of the medical record documents that the patient has a T-cell lymphoma. There are no marker studies on the chart. Code the grade as T-cell.

Sarcoma

If sarcomas are graded low, intermediate or high grade by the pathologist use the three-grade system table.

DIAGNOSTIC CONFIRMATION

Microscopically Confirmed

1 Positive histology
2 Positive cytology, no positive histology
4 Positive microscopic confirmation, method not specified

Not Microscopically Confirmed

5 Positive laboratory test/marker study
6 Direct visualization without microscopic confirmation
7 Radiography and other imaging techniques without microscopic confirmation
8 Clinical diagnosis only (other than 5, 6, or 7)

Confirmation Unknown

9 Unknown whether or not microscopically confirmed
Note: The lower number takes priority over all higher numbers.

Diagnostic Confirmation indicates whether *AT ANY TIME* during the patient's medical history there was microscopic confirmation of the morphology of this cancer. It indicates not only the fact of microscopic confirmation but the nature of the best evidence available. Thus, this is a priority series with code 1 taking precedence.

Code 1: Microscopic diagnoses based upon tissue specimens from biopsy, frozen section, surgery, autopsy, or D and C. Positive hematologic findings relative to leukemia, including peripheral blood smears, are also included. Bone marrow specimens (including aspiration biopsies) are coded as >1.=

Code 2: Cytologic diagnoses based on microscopic examination of cells as contrasted with tissues. Included are smears from sputum, bronchial brushings, bronchial washings, tracheal washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, and urinary sediment. Cervical and vaginal smears are common examples. Also included are diagnoses based upon paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.

Code 4: Diagnoses stated to be microscopically confirmed but with no detailed information on method.

Code 5: Clinical diagnosis of cancer based on certain laboratory tests or marker studies which are clinically diagnostic for cancer. Examples are the presence of alpha-fetoprotein for liver cancer and an abnormal electrophoretic spike for multiple myeloma and Waldenstrom's macroglobulinemia. Although elevated PSA is non-diagnostic of cancer, if the physician uses the PSA as a basis for diagnosing prostate cancer with no other work-up, it should be recorded as code 5.

Code 6: Visualization includes diagnosis made at surgical exploration or by use of the various endoscopes (including colposcope, mediastinoscope, peritoneoscope). However, use only if such visualization is not supplemented by positive histology or positive cytology reports. Also use when gross autopsy findings are the only positive information.

Code 7: Cases with diagnostic radiology for which there is neither a positive histology nor a positive cytology report. "Other imaging techniques" include procedures such as ultrasound, computerized (axial) tomography (CT or CAT) scans, and magnetic resonance imaging (MRI).

Code 8: Cases diagnosed by clinical methods not mentioned above and for which there were no positive microscopic findings.

Code 9: Cases for which it is unknown whether or not they have been microscopically confirmed. Also included are all "Death Certificate-Only" cases.

COLLABORATIVE STAGE

Please refer to the Collaborative Staging Manual and Coding Instructions for codes and instructions. Schemas for the collaborative staging system apply to cases diagnosed January 1, 2004 and later. For cases diagnosed prior to January 1, 2004 please refer to the coding system applicable to the time of diagnosis.

The Collaborative Staging System is a carefully selected set of data items that describe how far a cancer has spread at the time of diagnosis. Most of the data items have traditionally been collected by cancer registries, including tumor size, extension, lymph node status, and metastatic status. New items were created to collect information necessary for the conversion algorithms, including the evaluation fields that describe how the collected data were determined, and site/histology-specific factors that are necessary to derive the final stage grouping for certain primary cancers. In addition to the items coded by the registrar, this unified data set also includes several data items derived from the computer algorithms that classify each case in multiple staging systems: the sixth edition of the AJCC TNM system (TNM), Summary Stage 1977 (SS77), and SEER Summary Stage 2000 (SS2000).

FIRST-COURSE OF THERAPY

All Diseases (including Benign and borderline intracranial & CNS tumors) Except Leukemia and Hematopoietic Diseases

Definitions

Cancer tissue: Proliferating malignant cells; an area of active production of malignant cells. Cancer tissue includes primary tumor and metastatic sites where cancer tissue grows. Cells in fluid such as pleural fluid or ascitic fluid are not “cancer tissue” because the cells do not grow and proliferate in the fluid.

Disease recurrence: The patient must have had a disease-free interval or remission (the cancer was not clinically evident). Following a disease-free interval, there is documentation that the initial/original tumor gave rise to the later tumor.

First-course of therapy: All of the treatments administered to the patient after the original diagnosis of cancer in an attempt to destroy or modify the cancer tissue. See below for detailed information on timing and treatment plan documentation requirements.

Palliative treatment: The World Health Organization describes palliative care as treatment that improves the quality of life by preventing or relieving suffering. Palliative therapy is also part of the first-course of therapy when the treatment destroys or modifies cancer tissue. Palliative therapy may also be part of the first-course of therapy if it destroys proliferating cancer tissue.

> ***Example:*** The patient was diagnosed with stage IV cancer of the prostate with painful boney metastases. The patient starts radiation treatment intended to shrink the tumor in the bone and relieve the intense pain. The radiation treatments are palliative because they relieve the bone pain. The radiation is also first-course of therapy because it destroys proliferating cancer tissue.

Surgical Procedure: Any surgical procedure coded in the fields Surgery of Primary Site, Scope of Regional Lymph Node Surgery, or Surgery of Other Regional or Distant Sites.

Treatment: Procedures that destroy or modify primary (primary site) or secondary (metastatic).cancer tissue.

Treatment failure: The treatment modalities did not destroy or modify the cancer cells. The tumor either became larger (disease progression) or stayed the same size after treatment.

Watchful waiting: A treatment option for patients with slow, indolent diseases, such as prostate cancer and chronic lymphocytic leukemia (CLL). The physician closely monitors the patient and delays treatment until the patient becomes symptomatic or there are other signs of disease progression, such as rising PSA.

Treatment Timing

Use the following instructions in hierarchical order.

1. When there is **no documentation** of a treatment plan, a progression, recurrence or a treatment failure, first course ends one year after the date of diagnosis. Any treatment given after one year use the **documented** first-course of therapy from the medical record. First course ends when the treatment plan is **completed**. (No matter how long it takes to complete the plan).

   Example 1: First-course of treatment for childhood leukemia typically spans two years from induction, consolidation, to maintenance.

   Example 2: The first-course of therapy for a breast cancer patient is surgery, chemotherapy, and radiation. The patient completes surgery and chemotherapy. Bone metastases are diagnosed before the radiation was started. The physician says that the patient will start the radiation treatment as planned. Code the radiation as first-course of therapy since it was given in agreement with the treatment plan and the treatment plan was not changed as a result of disease progression.

2. First-course of therapy ends when there is documentation of disease progression, recurrence or treatment failure.

   Example 1: The documented treatment plan for sarcoma is chemotherapy, surgery, then radiation or chemotherapy depending upon the pathology from surgery. Scans show the tumor is not regressing after chemotherapy. Plans for surgery are cancelled and a different type of chemotherapy is started. Code only the first chemotherapy as first course. Do not code the second chemotherapy as first course because it is administered after documented treatment failure.

   Example 2: The documented treatment plan for a patient with locally advanced breast cancer includes mastectomy, chemotherapy, radiation to the chest wall and axilla, and hormone therapy. The patient has the mastectomy and completes chemotherapy. During the course of radiation therapy, the liver enzymes are rising. Workup proves liver metastases. The physician stops the radiation and does not continue with hormone therapy (the treatment plan is altered). The patient is placed on a clinical trial to receive Hercepton for metastatic breast cancer. Code the mastectomy, chemotherapy, and radiation as first-course of treatment. Do not code the Hercepton as first-course of therapy because it is administered after documented disease progression.

3. When there is no documentation of a treatment plan, a progression, recurrence or a treatment failure, first course ends one year after the date of diagnosis. Any treatment given after one year is second-course of therapy in the absence of a documented treatment plan or a standard of treatment.

Coding Instructions

1. When physician decides to do watchful waiting for a patient who has prostate cancer, the first-course of therapy is no treatment. Code all of the treatment fields to 00, not done. When the disease progresses and the patient are symptomatic; any prescribed treatment is second course.

2. When the patient refuses treatment, the first-course of therapy is no treatment. Code all of the treatment fields to refused. If the patient later changes his/her mind and decides to have the prescribed treatment code:

    a. Code the treatment as first-course of therapy if it has been less than one year since the cancer was diagnosed and there has been no documented disease progression.
    b. Code the treatment as second-course of therapy if it has been more than one year since the original cancer was diagnosed or if there has been documented disease progression.

3. Code all treatment that was started and administered.

    Example: The patient completed only the first dose of a planned 30 day chemotherapy regimen. Code chemotherapy as administered.

4. If a patient has multiple primaries and the treatment given for one primary also affects/treats the other primary, code the treatment for both primary sites.

    Example 1*:* The patient had prostate and bladder cancer. The bladder cancer was treated with a TURB. The prostate cancer was treated with radiation to the prostate and pelvis. The pelvic radiation includes the regional lymph nodes for the bladder. Code the radiation as treatment for both the bladder and prostate cases.

    Example 2: The patient had a hysterectomy for ovarian cancer. The pathology report reveals a previously unsuspected microinvasive cancer of the cervix. Code the hysterectomy as surgical treatment for both the ovarian and cervix primaries.

5. If a patient has multiple primaries and the treatment given affects only one of the primaries, code the treatments only on the site that is affected.

    Example: The patient has colon and tonsil primaries. The colon cancer is treated with a hemicolectomy and the tonsil primary is treated with radiation to the tonsil and regional nodes. Do not code the radiation for the colon. Do not code the hemicolectomy for the tonsil.

6. If a patient is diagnosed with an unknown primary, code the treatment given as first course even if the correct primary is identified later.

    Example: The patient is diagnosed with metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Hormonal treatment is started. Code the chemotherapy as first-course of treatment. The hormone therapy is second course.

7. Code the individual treatment fields to 0 or 00 [None] when the modality is not addressed in the treatment plan (or when a treatment plan is lacking) and there is no indication that a particular modality of treatment was recommended or started.

8. If a patient is offered many treatment options and chooses a non-surgical option, do not code refused surgery, code as not recommended. Example, Prostate cancer patient is offered a prostatectomy or radiation, the patient selects radiation. Code reason for no surgery as 1.

First course for Leukemia and Hematopoietic Diseases (diagnosed 1/2001 and after)

Leukemia:

Leukemia is grouped or typed by how quickly the disease develops and gets worse. **Chronic** leukemia gets worse **slowly**. **Acute** leukemia gets worse **quickly**.

Leukemias are also grouped by the **type** of **white blood cell** that is affected. The groupings are: **lymphoid** leukemia and **myeloid** leukemia.

Definitions

Consolidation: Repetitive cycles of chemotherapy given immediately after the remission.

Induction: Initial intensive course of chemotherapy.

Maintenance: Chemotherapy given for a period of months or years to maintain remission.

Remission: The bone marrow is normocellular with less than 5% blasts, there are no signs or symptoms of the disease, no signs or symptoms of central nervous system leukemia or other extramedullary infiltration, and all of the following laboratory values are within normal limits: white blood cell count and differential, hematocrit/hemoglobin level, and platelet count.

Treatment for leukemia is divided into **three phases**:

1. Remission induction (chemotherapy and/or biologic response modifiers)
2. CNS prophylaxis or consolidation (irradiation to brain, chemotherapy)
3. Remission continuation or maintenance (chemotherapy or bone marrow transplants).

Coding First-course of Therapy for Leukemia and Hematopoietic Diseases:

1. If a patient **has** a partial or complete **remission** during the first-course of therapy:

   a. Code all therapy that is “remission-inducing” as first course.
   b. Code all therapy that is “consolidation” as first course.
   c. Code all therapy that is “remission-maintaining” as first course.

   Note: Do not record treatment given after the patient relapses (is no longer in remission).

2. Some patients do not have a remission. A change in the treatment plan indicates a failure to induce remission. If the patient does not have a remission:

    d. Record the treatment given in an attempt to induce a remission.
    e. Do not record treatment administered after the change in treatment plan.

Other Hematopoietic Diseases

Record all treatments as described above. The following treatments are coded as "other" in Other Treatment even though they do not "modify, control, remove, or destroy proliferating cancer tissue." Follow the guidelines in the *Abstracting and Coding Guide for the Hematopoietic Diseases* to identify treatments. Some examples of "other" treatment include:

Example 1: **Phlebotomy** may be called blood removal, blood letting, or venisection.

Example 2: **Transfusions** may include whole blood, RBCs, platelets, plateletpheresis, fresh frozen plasma (FFP), plasmapheresis, and cryoprecipitate.

Example 3: **Aspirin** (also known as ASA, acetylsalicylic acid, or by a brand name) is used as a treatment for essential thrombocythemia.

a. Only record aspirin therapy if it is given to thin the blood for symptomatic control of thrombocythemia. Use the following guidelines to determine whether aspirin is administered for thinning of blood for thrombocythemia rather than for pain control or cardiovascular protection:

    i. Aspirin treatment for essential thrombocythemia is low dose, approximately 70-100 mg/day
    ii. The dosage for pain control is approximately 325-1000 mg every 3-4 hours.
    iii. Cardiovascular protection starts at about 160 mg/day.

No Cancer-Directed Therapy

"Cancer tissue" means proliferating malignant cells or an area of active production of malignant cells such as adjacent tissues or distant sites. In some instances, malignant cells are found in tissues where they did not originate and where they do not reproduce, such as malignant cells found at thoracentesis or paracentesis. Procedures that remove malignant cells, but do not treat a site of proliferating cells are not considered cancer therapy.

If the patient only receives supportive or symptomatic therapy, it is not considered cancer therapy. The term "palliative" can mean either non-curative or alleviation of symptoms. Therefore "palliative" can fall within the definition of cancer-directed treatment or non-cancer directed therapy. Surgical procedures performed to diagnose/stage disease (exploratory) or for relief of symptoms (palliative) are considered diagnostic, staging, and palliative procedures.

Date Therapy Initiated

Record the start date of the first-course of therapy. This may be the start date of any type of treatment for this tumor; surgery, chemotherapy, radiation therapy, or other types of therapy. Treatment might be given in a hospital or non-hospital setting. Date fields are recorded in the month, day, century, year format (MMDDCCYY) with 99 for unknown day or month and 9999 for unknown year.

Code/Month

01	January
02	February
03	March
04	April
05	May
06	June
07	July
08	August
09	September
10	October
11	November
12	December
99	Unknown

Codes for Day

01
02
03
..
..
31
99 Unknown day

Year

All four digits of year
9999 Unknown

Special Codes

00000000	No date, no first-course treatment performed
99999999	Unknown date

Definitions

Cancer-directed therapy: Treatment administered to the patient in an attempt to destroy or modify cancer tissue.

Note: Surgical procedures coded in the data items Scope of Regional Lymph Node Surgery and Surgical Procedure of Other Site are not necessarily cancer-directed therapy.

Coding Instructions

1. Code **00000000** if no therapy was given.

   a. If there was no first-course therapy. For example, the patient had ONLY biopsy, bypass, or "watchful waiting"
   b. Autopsy only cases

2. Code the **start date** of the first therapy. The first therapy may be coded in the following data items:

   - Surgery of Primary Site
   - Scope of Regional Lymph Node Surgery
   - Surgical Procedure of Other Site
   - Radiation Therapy
   - Chemotherapy
   - Hormone Therapy
   - Immunotherapy,
   - Hematologic Transplant and Endocrine Procedures
   - Other Therapy

3. Code the date of **excisional biopsy** as the date therapy initiated if it is the first treatment. Code the date of a biopsy documented as incisional if further surgery reveals no residual or only microscopic residual.

   Example: Breast core needle biopsy with diagnosis of infiltrating duct carcinoma; subsequent re-excision with no residual tumor noted. Code the date of the needle biopsy as the excisional biopsy date.

4. Code the date unproven therapy was initiated as the date therapy initiated.

5. If the exact **date** of the first treatment is **unknown**, code the date of admission to the hospital for inpatient or outpatient treatment.

6. Code **99999999**
   a. It is known the patient had first-course therapy, but it is impossible to estimate the date
   b. Death certificate only cases

When an unproven therapy (e.g., laetrile) is the first-course of therapy, code the date the patient started taking that therapy (these treatments are coded in the field "Other Cancer-Directed Therapy").

Cancer-Directed Therapy
General Surgery Coding Rules

The NJSCR collects the following site specific surgery scheme:

Surgery of Primary Site	2 digits
Scope of Regional Lymph Node Surgery	1 digit
Number of Regional Lymph Nodes Examined	2 digits
Surgical Procedure of Other Site	1 digit

The surgery codes that should be used can be found in Appendix M or the SEER Program Coding and Staging Manual 2004 or FORDS 2004. The NJSCR does not require surgical approach or margins to be coded.

- Once it is determined that cancer-directed surgery was performed, use the best information in the operative/pathology reports to determine the operative procedure. Do *NOT* depe*nd on the name of the procedure since it may be incomplete.*

- If the operative report is unclear as to what was excised or if there is a discrepancy between the operative and pathology reports, use the pathology report, unless there is reason to doubt its accuracy.

- If a surgical procedure removes the remaining portion of an organ which had been partially resected previously for any condition, code as total removal of the organ. If none of the primary organ remains, the code should indicate that this is the case.

  For example:
  1. Resection of a stomach which had been partially excised previously is coded as total removal of stomach.
  2. Removal of a cervical stump is coded as total removal of uterus.
  3. Lobectomy of a lung with a previous wedge resection is coded as total removal of lobe.

- Any lymph node dissection done as a separate procedure within the first-course of cancer-directed therapy is to be coded.

- If an excisional biopsy is followed by "re-excision" or "wide excision" within the first-course of cancer-directed therapy, include that later information in coding site-specific surgery.

- If multiple primaries are excised at the same time, code the appropriate surgery for each site. *For example:* 1) If a total abdominal hysterectomy was done for a patient with two primaries, one of the cervix and one of the endometrium, code each as having had a total abdominal hysterectomy. 2) If a total colectomy was done for a patient with multiple primaries in several segments of the colon, code total colectomy for each of the primary segments.

- Ignore the use of laser if used only for the initial incision.

- Surgical procedures performed solely for the purpose of establishing a diagnosis/stage or for the relief of symptoms, and procedures such as brushings, washings, and aspiration of cells as well as hematologic findings (peripheral blood smears) are not considered cancer therapy and are not to be coded.

- Surgery for extranodal lymphomas should be coded using the scheme for the extranodal site. *For example:* a lymphoma of the stomach is to be coded using the scheme for stomach.

Surgery of Primary Site

Surgery of Primary Site describes a surgical procedure that removes and/or destroys tissue of the primary site performed as part of the initial work-up or first-course of therapy. Site-specific surgery codes are found in Appendix M or the SEER Program Manual 2004 or in FORDS 2004.

General Coding Structure

00	None; no surgical procedure of primary site; diagnosed at autopsy only
10-19	Site-specific codes. Tumor destruction; no pathologic specimen or unknown whether there is a pathologic specimen
20-80	Site-specific codes. Resection; pathologic specimen
90	Surgery, NOS. A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.
98	Special codes for hematopoietic, reticuloendothelial, immunoproliferative, myeloproliferative diseases; ill-defined sites; and unknown primaries (See site-specific codes for the sites and histologies), except death certificate only
99	Unknown if surgery performed; death certificate-only

Coding Instructions

1. Code 00 if **no surgery** is performed on the primary site or if case was diagnosed at **autopsy, and would not be otherwise coded to 98.**

2. Use the site-specific coding scheme corresponding to the coded primary site.

3. Code the most **invasive, extensive, or definitive** surgery if the patient has multiple surgical procedures of the primary site even if there is no tumor found in the pathologic specimen. The codes in the range of 00-80 are **listed** in hierarchical but not necessarily numerical order. When more than one surgical procedure is performed, code the procedure listed furthest down the list within the codes 10-80.

   Example: Patient has a needle biopsy of prostate that is positive for adenocarcinoma. The patient chooses to have a radical prostatectomy. The pathologic examination of the prostatectomy specimen shows no residual tumor. Code the radical prostatectomy.

4. Code an **excisional biopsy,** even when documented as **incisional**, when:
   a. All disease is removed (**margins free**) OR
   b. All gross disease is removed and there is only **microscopic residual at the margin.**

Note: Do not code an excisional biopsy when there is macroscopic residual disease.

5. Code **total removal of the primary site** when a previous procedure resected a portion of the site and the current surgery removed the rest of the organ. The previous procedure may have been cancer directed or non-cancer directed surgery.

6. Code the removal of regional or distant **tissue/organs** when they are resected in continuity with the primary site (**en bloc)**. Specimens from an en bloc resection may be submitted to pathology separately.

   Example: Code an en bloc removal when the patient has a hysterectomy and an omentectomy.

7. Code surgery for extra-lymphatic lymphoma using the site-specific surgery coding scheme (not lymph node scheme) for the primary site.

8. Code **80** or **90** only when there is no specific information.

9. Code **98** for the following sites unless the case is death certificate only:

   a. Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease

      i. Primary sites: C420, C421, C423, or C424 AND
      ii. Histologies: 9750, 9760-9764, 9820-9822, 9826, 9831-9920, 9931-9964, 9980-9989

   b. Unknown or ill-defined sites (C760-C768, C809)

10. Assign **code 99** for death certificate only (DCO) cases.

Scope of Regional Lymph Node Surgery

Scope of Regional Lymph Node Surgery describes the procedure of removal, biopsy, or aspiration of **regional** lymph nodes performed during the initial work-up or first-course of therapy.

Codes

0 No regional lymph nodes removed or aspirated; diagnosed at autopsy.
1 Biopsy or aspiration of regional lymph node, NOS
2 Sentinel lymph node biopsy [only]
3 Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS
4 1 to 3 regional lymph nodes removed
5 4 or more regional lymph nodes removed
6 Sentinel node biopsy and code 3, 4, or 5 at same time or timing not noted
7 Sentinel node biopsy and code 3, 4, or 5 at different times
9 Unknown or not applicable; death certificate only

Coding Instructions

1. Code 0 when regional lymph node removal procedure was not performed.

2. Code regional lymph node procedures in this data item. Record distant lymph node removal in Surgical Procedure of Other Site.

3. Codes 1-7 are **hierarchical**. Code the procedure that is numerically higher.

4. The regional lymph node surgical procedure(s) may be done to **diagnose** cancer, **stage** the disease, or as a part of the initial **treatment**. Record all surgical procedures that remove, biopsy, or aspirate regional lymph node(s) whether or not there were any surgical procedures of the primary site.

Example: Patient has a sentinel node biopsy of a single lymph node. Assign code 2 (Sentinel lymph node biopsy [only]).

5. The Scope of Regional Lymph Node field is **cumulative**; add the number of all of the lymph nodes removed during each surgical procedure performed as part of the first-course of treatment.

Example: Patient has a positive cervical node biopsy. The pathology report from a subsequent node dissection identifies three cervical nodes. Assign code 5 (4 or more regional lymph nodes removed).

6. If the operative report lists a lymph node dissection, but **no nodes were found by the pathologist,** code the Scope of Regional Lymph Node Surgery to 0 (No lymph nodes removed)

7. If the patient has **two primaries with common regional lymph nodes**, code the removal of regional nodes for both primaries.

Example: Patient has a cystoprostatectomy and pelvic lymph node dissection for bladder cancer. Pathology identifies prostate cancer as well as the bladder cancer and 4/21 nodes positive for metastatic adenocarcinoma. Code Scope of Regional Lymph Node Surgery to 5 (4 or more regional lymph nodes removed) for both primaries.

8. Assign **code 9** for

   a. Primary sites

      i. Brain (C700-C709) OR
      ii. Spinal cord (C710-C719) OR
      iii. Cranial nerves and other parts of the central nervous system (C720-C729)

   b. Lymphoma with primary site in lymph nodes (C770-C779) AND histology

      i. 9590-9596 OR
      ii. 9650-9719 OR
      iii. 9727-9729

   c. Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease

      i. Primary sites: C420, C421, C423, or C424 AND
      ii. Histologies: 9750, 9760-9764, 9820-9822, 9826, 9831-9920, 9931-9964, 9980-9989
      iii. Unknown or ill-defined sites (C760-C768, C809)

Surgical Procedure of Other Site

Surgical Procedure of Other Site describes the surgical removal of distant lymph node(s) or other tissue(s) or organ(s) beyond the primary site.

Codes

0 None; diagnosed at autopsy
1 Non-primary surgical procedure performed
2 Non-primary surgical procedure to other regional sites
3 Non-primary surgical procedure to distant lymph node(s)
4 Non-primary surgical procedure to distant site
5 Combination of codes 2, 3, or 4
9 Unknown; death certificate only

Coding Instructions

1. Code 0 when no surgical procedures were performed that removed distant lymph node(s) or other tissue(s) or organ(s) beyond the primary site.

2. The codes are **hierarchical**. Code the procedure that is numerically higher.

3. Codes 1-5 have priority over codes 0 and 9

4. Do not code tissue or organs such as an appendix that were removed **incidentally,** and the organ was not involved with cancer.

Note: Incidental removal of organs means that tissue was removed for reasons other than removing cancer or preventing the spread of cancer. Examples of incidental removal of organ(s) would be removal of appendix, gallbladder, etc. during abdominal surgery.

Reason for No Surgery of Primary Site

Record the reason that surgery was not performed on the primary site.

Codes

0 Surgery of the primary site was performed
1 Surgery of the primary site was not performed because it was not part of the planned first-course treatment
2 Surgery of the primary site was not recommended/performed because it was contraindicated due to patient's risk factors (co-morbid conditions, advanced age, etc.)
5 Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery
6 Surgery of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first-course of therapy. No reason was noted in the patient's record.
7 Surgery of the primary site was not performed; it was recommended by the patient's physician, but was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient's record.
8 Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow up is recommended.
9 It is unknown if surgery of the primary site was recommended or performed; death certificate only cases and autopsy only cases.

Coding Instructions

1. Assign **code 0** when Surgery of Primary Site is coded in the range of 10-90 (the patient did have surgery of primary site)

2. Assign a code in the **range of 1-8** if Surgery of Primary Site is coded 00 or 98.

3. Assign **code 1**

    a. There is no information in the patient's medical record about surgery AND

        i. It is known that surgery is not usually performed for this type and/or stage of cancer OR
        ii. There is no reason to suspect that the patient would have had surgery of primary site.

    b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include surgery of the primary site, or patient elects to pursue no treatment following the discussion of radiation treatment. Discussion does not equal a recommendation.
    c. Only information available is that the patient was referred to a surgeon. Referral does not equal a recommendation.
    d. Watchful waiting (prostate)
    e. Patient diagnosed at autopsy

4. Assign **code 6**

    a. When it is known that surgery was recommended AND
    b. It is known that surgery was not performed AND
    c. There is no documentation explaining why surgery was not done.

5. Assign **code 7** (refused) if the patient refused recommended surgery, or made a blanket statement that he/she refused all treatment.

6. Assign **code 8** (unknown) if the treatment plan offered surgery, but it is unknown if the patient actually had the surgery.

7. Assign **code 9**

    a. When there is no documentation that surgery was recommended or performed
    b. Death certificate only.
    c. Autopsy only (Diagnosis 1/1/2003)

Radiation Therapy

Record the type and date (MMDDCCYY) of radiation administered to the primary or metastatic site. Record any type of radiation in this field regardless of source, field being treated or intent of treatment (curative or palliative). Include all procedures that are a part of the first-course of treatment, whether delivered at the reporting institution or at others.

REGIONAL TREATMENT MODALITY
Coding Instructions:

Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first-course of treatment. Segregation of treatment components into regional and boost and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding. In the event multiple radiation therapy modalities were employed in the treatment of the patient, record only the dominant modality.

Note that in some circumstances the boost treatment may precede the regional treatment.

For purposes of this data item, photon and x-rays are equivalent. For additional information regarding these codes, please see the FORDS Manual.

Code	Label
00	No radiation treatment
20	External beam, NOS
21	Orthovoltage
22	CobaltB60, CesiumB137
23	Photons (2B5 MV)
24	Photons (6B10 MV)
25	Photons (11B19 MV)
26	Photons (>19 MV)
27	Photons (mixed energies)
28	Electrons
29	Photons and electrons mixed
30	Neutrons, with or without photons/electrons
31	IMRT
32	Conformal or 3BD therapy
40	Protons
41	Stereotactic radiosurgery, NOS
42	Linac radiosurgery
43	Gamma Knife
50	Brachytherapy, NOS
51	Brachytherapy, Intracavitary, LDR
52	Brachytherapy, Intracavitary, HDR
53	Brachytherapy, Interstitial, LDR
54	Brachytherapy, Interstitial, HDR
55	Radium
60	Radioisotopes, NOS
61	StrontiumB89
62	StrontiumB90
80*	Combination modality, specified*
85*	Combination modality, NOS*

**Note:* Codes 80 and 85 should not be used to record regional radiation for cases diagnosed on or after 01/01/2003. These codes describe specific converted descriptions of radiation therapy coded according to Volume II, ROADS and DAM rules and FORDS Manual, page 157.

98	Other, NOS	
99	Unknown	It is unknown whether radiation therapy was administered.

BOOST TREATMENT MODALITY

Coding Instructions:

Radiation boost treatment modalities will typically be found in the radiation oncologist's summary letter for the first-course of treatment. Segregation of treatment components into regional and boost and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.

In the event multiple radiation therapy boost modalities were employed in the treatment of the patient, record only the dominant modality.

Note that in some circumstances the boost treatment may precede the regional treatment.

For purposes of this data item, photon and x-rays are equivalent. For additional information regarding these codes, please see the FORDS Manual.

Code	Label
00	No radiation treatment
20	External beam, NOS
21	Orthovoltage
22	CobaltB60, CesiumB137
23	Photons (2B5 MV)
24	Photons (6B10 MV)
25	Photons (11B19 MV)
26	Photons (>19 MV)
27	Photons (mixed energies)
28	Electrons
29	Photons and electrons mixed
30	Neutrons, with or without photons/electrons
31	IMRT
32	Conformal or 3BD therapy
40	Protons
41	Stereotactic radiosurgery, NOS
42	Linac radiosurgery
43	Gamma Knife
50	Brachytherapy, NOS
51	Brachytherapy, Intracavitary, LDR
52	Brachytherapy, Intracavitary, HDR

53	Brachytherapy, Interstitial, LDR	
54	Brachytherapy, Interstitial, HDR	
55	Radium	
60	Radioisotopes, NOS	
61	StrontiumB89	
62	StrontiumB90	
98	Other, NOS	
99	Unknown	It is unknown whether radiation therapy was administered.

RX Summ - Radiation (For Central Registry Purposes) This will be determined by the Central Registry based on the information provided in the Regional Treatment Modality and Boost Treatment Modality fields.

Code	
0	None
1	Beam radiation
2	Radioactive implants
3	Radioisotopes
4	Combination of 1 with 2 or 3
5	Radiation, NOS - method or source not specified
7	Patient or patient's guardian refused radiation therapy
8	Radiation recommended, unknown if administered
9	Unknown

This field was previously named "Radiation."

Coding Guidelines
Record any type of radiation therapy in this field regardless of source, field being treated, or intent of treatment (curative or palliative). For cases diagnosed 1/1/1998 and after, include prophylactic radiation to the brain and/or central nervous system in this field.

Coding Instructions:

1. Assign **code 0**

    a. There is no information in the patient's medical record about radiation AND

        i. It is known that radiation is not usually performed for this type and/or stage of cancer OR
        ii. There is no reason to suspect that the patient would have had radiation.

    b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include radiation
    c. Patient elects to pursue no treatment following the discussion of radiation treatment. Discussion does not equal a recommendation.

d. Only information available is that the patient was referred to a radiation oncologist. Referral does not equal a recommendation.
e. Watchful waiting (prostate)
f. Patient diagnosed at autopsy

2. Assign **code 1** for beam radiation directed to cancer tissue. The source of the beam radiation is not used for coding purposes. Sources may include, but are not limited to: X-ray, Cobalt, linear accelerator, neutron beam, betatron, spray radiation, stereotactic radiosurgery such as gamma knife and proton beam.

3. Assign **code 2** when the radiation is delivered by interstitial implant, molds, seeds, needles or intracavitary applicators. The radioactive material used in implants includes, but is not limited to: cesium, radium, radon, radioactive gold, and iodine.

4. Assign **code 3** when radioactive isotopes are given orally, intracavitary or by intravenous injection. Radioactive isotopes include but are not limited to: I-131 or P-32.

5. Assign **code 4** when beam radiation is given in combination with either radioactive implants or radioactive isotopes.

6. Assign **code 5** when the type of radiation, method or source is not specified.

7. If the patient has more than two radiation types, code the dominant type (the greatest dose of radiation). Determination of the respective treatment modalities may require assistance from the radiation oncologist to ensure consistent coding.

8. For cases diagnosed prior to 1/1/1998, radiation to the brain and/or central nervous system for lung and leukemia cases was coded in the field Radiation to the Brain and/or Central Nervous System.

9. Assign **code 9**

   a. When there is no documentation that radiation was recommended or performed
   b. Death certificate only.

Radiation treatment descriptions will typically be found in the radiation oncologist's summary letter for the first-course of treatment.

Translation of Regional Treatment Modality and/or Boost Treatment Modality Field to RX Summ - Radiation

RX Summ -Radiation	Code	Regional Treatment Modality and/or Boost Treatment
0 None	00	No radiation treatment
1 Beam radiation	20	External beam, NOS
	21	Orthovoltage
	22	Cobalt-60, Cesium-137
	23	Photons (2-5 MV)
	24	Photons (6-10 MV)
	25	Photons (11-19 MV)
	26	Photons (>19 MV)
	27	Photons (mixed energies)
	28	Electrons
	29	Photons and electrons mixed
	30	Neutrons, with or without photons/electrons
	31	IMRT
	32	Conformal or 3-D therapy
	40	Protons
	41	Stereotactic radiosurgery, NOS
	42	Linac radiosurgery
	43	Gamma Knife
2 Radioactive implants	50	Brachytherapy, NOS
	51	Brachytherapy, intracavitary, LDR
	52	Brachytherapy, intracavitary, HDR
	53	Brachytherapy, interstitial, LDR
	54	Brachytherapy, interstitial, HDR
	55	Radium
3 Radioisotopes	60	Radioisotopes, NOS
	61	Strontium-89
	62	Strontium-90
4 Combination of 1 with 2 or 3	80	Combination modality, specified
	85	Combination modality, NOS
5 Radiation therapy, NOS, method or source unspecified	98	Other, NOS
9 Unknown	99	Unknown

If a code for TX Summ-Radiation is not received from hospital registrars, the code can be derived from the following sources if radiation is not received from hospital registries. The code for RX Summ—Radiation is derived from Rad-Boost RX Modality, Rad-Regional TX Modality, and/or Reason For No Radiation.

Radiation Sequence with Surgery

This field records the order in which surgery and radiation therapies were administered for those patients who had **both surgery and radiation**. For the purpose of coding Radiation Sequence with Surgery, 'Surgery' is defined as a Surgical Procedure to the Primary Site (codes 10-90) or Scope of Regional Lymph Node Surgery (codes 1-7) or Surgical Procedure of Other Site (codes 1-5).

Codes

0 No radiation and/or surgery as defined above
2 Radiation before surgery
3 Radiation after surgery
4 Radiation both before and after surgery
5 Intraoperative radiation therapy
6 Intraoperative radiation with other radiation given before or after surgery
9 Sequence unknown, but both surgery and radiation were given

Definition

Surgery: Surgical Procedure to the Primary Site (codes 10-90) or Scope of Regional Lymph Node Surgery (codes 1-7) or Surgical Procedure of Other Site (codes 1-5).

Coding Instructions

Assign code 0 when

- The patient did not have either surgery or radiation.
- The patient had surgery but not radiation.
- The patient had radiation but not surgery

Note: For cases diagnosed prior to 1/1/1998, Radiation to the Brain and/or Central Nervous System was counted as radiation when coding this field.

Assign codes 2-9 when first-course of therapy consists of both cancer-directed surgery and radiation therapy.

DATE SYSTEMIC THERAPY STARTED

Date Systemic Therapy Started
Record the date of initiation for systemic therapy that is part of the first-course of treatment. Systemic therapy includes the administration of chemotherapy agents, hormonal agents, biological response modifiers, bone marrow transplants, stem cell harvests and surgical and/or radiation endocrine therapy. This data field should include dates for agents that have been administered locally such as those given intravesical or intrathecal therapy, such as BCG instilled into the bladder.

Record the first or earliest date on which systemic therapy was administered. Systemic therapy includes Chemotherapy, Hormonal Therapy, Immunotherapy, Hematologic Transplant and Endocrine Procedures.

Code 88888888 if systemic therapy was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up. The updated abstract should then be printed with the correction highlighted then mailed to the NJSCR.

Code	Definition
00000000	When no systemic therapy is administered. Diagnosed at autopsy.
88888888	When systemic therapy is planned as part of the first-course of therapy, but had not been started at the time of the most recent follow-up. The date should be revised at the next follow- up.
99999999	When it is unknown if any systemic therapy was administered, the date is unknown, or the case was identified by death-certificate only.

Chemotherapy

The data item Chemotherapy records the chemotherapy given as a part of the first-course of treatment or the reason that chemotherapy was not given. See *SEER Self Instructional Manuals for Tumor Registrars Book 8* for chemotherapy drug codes. See SEER*Rx www.seer.cancer.gov/tools/seerrx for cases diagnosed 1/1/2005 and after .

Chemotherapeutic agents are chemicals that affect cancer tissue by means other than hormonal manipulation. The agents inhibit the production of cancer cells by interfering with DNA synthesis and mitosis. They may be divided into three classes with respect to their dependence on the cell cycle.

1. Alkylating agents are **not cell-cycle-specific**. Although they are toxic to all cells, they are especially toxic to proliferating cells.

2. Other drugs are **cell-cycle-specific**. Cells must be proliferating for these drugs to be effective.

3. Cell-cycle-specific drugs may also be **cell-cycle phase-specific**; such drugs are active only in one stage of the cell cycle.

Chemotherapy agents are also grouped by their ingredients and the way they attack the cells. Those groups are:

1. Alkylating
2. Antimetabolites
3. Natural products
4. Other miscellaneous

Codes

00 None, chemotherapy was not part of the planned first-course of therapy; diagnosed at autopsy
01 Chemotherapy administered as first-course therapy, but the type and number of agents is not documented in the patient's record.
02 Single agent chemotherapy administered as first-course therapy.
03 Multiagent chemotherapy administered as first-course therapy.
82 Chemotherapy was not recommended/administered because it was contraindicated due to patient's risk factors (comorbid conditions, advanced age, etc.).

85 Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86 Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first-course of therapy. No reason was stated in patient's record.
87 Chemotherapy was not administered. It was recommended by the patient's physician, but the treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient's record.
88 Chemotherapy was recommended, but it is unknown if it was administered.
99 It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in the patient's record. Death certificate only.

Definitions

Chemotherapy recommended: There was a consult recommending chemotherapy or the attending physician documented that chemotherapy was recommended. A referral to a clinical oncologist does not equal a recommendation.

Multiple agent chemotherapy: Two or more chemotherapeutic agents were administered to destroy cancer tissue during the first-course of therapy. The chemotherapeutic agents may or may not have been administered with other drugs classified as immunotherapy, hormone therapy, ancillary or other treatment.

Single agent chemotherapy: Only one chemotherapeutic agent was administered to destroy cancer tissue during the first-course of therapy. The chemotherapeutic agent may or may not have been administered with other drugs classified as immunotherapy, hormone therapy, ancillary, or other treatment.

Coding Instructions

1. Code the chemotherapeutic agents whose actions are chemotherapeutic only; **do not code** the method of **administration**.

2. When chemotherapeutic agents are used as radiosensitizers or radioprotectants, they are given at a much lower dosage and do not affect the cancer. Radiosensitizers and radioprotectants are classified as ancillary drugs. Do not code as chemotherapy.

3. The physician may change a drug during the first-course of therapy because the patient cannot tolerate the original agent. If the chemotherapeutic agent that is substituted belongs to the same group (alkylating, antimetabolites, natural products, or other miscellaneous), this is a continuation of the first-course of therapy. If treated with a single agent and this agent is changed to another single agent in the same group code remains 02 single agent.

4. Assign **code 00** when

    a. There is no information in the patient's medical record about chemotherapy AND

i. It is known that chemotherapy is not usually performed for this type and/or stage of cancer OR
ii. There is no reason to suspect that the patient would have had chemotherapy.

b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include chemotherapy
c. Patient elects to pursue no treatment following the discussion of chemotherapy Discussion does not equal a recommendation.
d. Only information available is that the patient was referred to a clinical oncologist. Referral does not equal a recommendation.
e. Watchful waiting (CLL)
f. Patient diagnosed at autopsy

Example: Patient is diagnosed with multiple myeloma. There is no mention of treatment or treatment plans in the medical record. Follow-back finds that the patient died three months after diagnosis. There are no additional medical records or other pertinent information available. Assign code 00 since there is no reason to suspect that the patient had been treated.

5. Do not code combination of ancillary drugs administered with single agent chemotherapeutic agents as multiple chemotherapy. For example the administration of 5-FU (antimetabolite) and Leucovorin (ancillary drug) is coded to single agent (Code 02).

6. Assign **code 82** when the physician would have recommended chemotherapy but did not due to patient risk factors, such as:

   b. Advanced **age**
   c. **Comorbid** condition(s) (heart disease, kidney failure, other cancer, etc.).

7. Assign **code 99**
   a. When there is no documentation that chemotherapy was recommended or performed
   b. Death certificate only.

Hormone Therapy

The data item Hormone Therapy records therapy administered as first-course treatment that affects cancer tissue by changing the patient's hormone balance. See *SEER Self Instructional Manuals for Tumor Registrars Book 8* for hormone therapy drug codes. For cases diagnosed 1/1/2005 and after, see SEER*Rx www.seer.cancer.gov/tools/seerrx.

Hormones may be divided into three categories:

1. Hormones.
2. Antihormones.
3. Adrenocorticotrophic agents

Codes

00 None, hormone therapy was not part of the planned first-course of therapy; not usually administered for this type and/or stage of cancer; diagnosed at autopsy only.
01 Hormone therapy administered as first-course therapy.
82 Hormone therapy was not recommended/administered because it was contra indicated due to patient risk factors (comorbid conditions, advanced age, etc.).
85 Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86 Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first-course of therapy. No reason was stated in the patient record.
87 Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88 Hormone therapy was recommended, but it is unknown if it was administered.
99 It is unknown whether a hormonal agent(s) was recommended or administered. Death certificate only.

Coding Instructions

1. Assign **code 00** when

    a. There is no information in the patient's medical record about hormone therapy AND

        i. It is known that hormone therapy is not usually performed for this type and/or stage of cancer OR
        ii. There is no reason to suspect that the patient would have had hormone therapy.

    b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include hormone therapy
    c. Patient elects to pursue no treatment following the discussion of hormone therapy treatment. Discussion does not equal a recommendation.
    d. Only information available is that the patient was referred to an oncologist. Referral does not equal a recommendation.
    e. Watchful waiting (prostate)
    f. Patient diagnosed at autopsy

2. Assign **code 99**

    a. When there is no documentation that surgery was recommended or performed
    b. Death certificate only.

3. Some types of cancer **thrive and proliferate because** of **hormones** (estrogen, progesterone and testosterone) that naturally occur in the body. These types of cancer may be treated by an **antihormone** or by the surgical removal/radiation of the organ(s) that produce the hormone, such as the testes and ovaries. **Surgical removal** of **organs** for hormone manipulation is not coded in this data item. Code these procedures in the data field Hematologic Transplant and Endocrine Procedures.

4. Other types of cancers are **slowed** or **suppressed** by **hormones**. These cancers are treated by administering hormones.

Example 1: Endometrial cancer may be treated with progesterone. Code all administration of progesterone to patients with endometrial cancer in this field. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer.

Example 2: **Follicular** and papillary cancers of the **thyroid** are often treated with thyroid hormone to suppress serum thyroid-stimulating hormone (TSH). If a patient with papillary and/or follicular cancer of the thyroid is given a thyroid hormone, code the treatment in this field.

5. Code the hormonal agent given as part of combination chemotherapy, e.g. MOPP, COPP whether it affects the cancer cells or not.

For cases diagnosed prior to 01/01/2003, endocrine surgery or radiation is to be coded in this field for breast and prostate only.

Breast:	*Prostate:*
oophorectomy	*orchiectomy*
adrenalectomy	*adrenalectomy*
hypophysectomy	*hypophysectomy*

Immunotherapy (Biological Response Modifier Therapy)

The data item Immunotherapy records immunotherapeutic (biological therapy, biotherapy or biological response modifier) agents administered as first-course of therapy.

Immunotherapy **uses** the body's **immune system**, either directly or indirectly, to fight cancer or to lessen the side effects that may be caused by some cancer treatments. Record only those treatments that are administered to affect the cancer cells.

Immunotherapy is **designed** to:

1. Make **cancer cells** more **recognizable** and, therefore, more **susceptible** to destruction by the immune system.
2. **Boost** the killing power of **immune** system cells, such as T-cells, NK-cells, and macrophages.
3. **Alter** cancer cells' **growth patterns** of cancer cells to promote behavior like that of healthy cells
4. **Block** or **reverse** the process that **changes** a normal cell or a pre-cancerous cell into a cancerous cell.
5. **Enhance** the body's ability to **repair** or **replace** normal cells damaged or destroyed by other forms of cancer treatment, such as chemotherapy or radiation.
6. **Prevent** cancer cells from **spreading** to other parts of the body.

Codes

00 None, immunotherapy was not part of the planned first-course of therapy; not customary therapy for this cancer; diagnosed at autopsy only.
01 Immunotherapy was administered as first-course therapy.
82 Immunotherapy was not recommended/administered because it was contraindicated due to patient's risk factors (comorbid conditions, advanced age etc.).

85 Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86 Immunotherapy was not administered; it was recommended by the patient's physician, but was not administered as part of the first-course of therapy. No reason was noted in the patient's record.
87 Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient's record.
88 Immunotherapy was recommended, but it is unknown if it was administered.
99 It is unknown if immunotherapy was recommended or administered because it is not stated in patient's record; death certificate only cases.

Definitions

Types of immunotherapy

Cancer Vaccines: Cancer vaccines are still in the experimental phase and are not coded in this data item. They may be coded in the field *Other Therapy*. Currently clinical trials use cancer vaccines for brain, breast, colon, kidney, lung, melanoma and ovary.

Interferons: Interferons belong to a group of proteins called cytokines. They are produced naturally by the white blood cells in the body. Interferon-alpha is able to slow tumor growth directly as well as activate the immune system. It is used for a number of cancers including multiple myeloma, chronic myelogenous leukemia (CML), hairy cell leukemia, and malignant melanoma.

Interleukins (IL-2) are often used to treat kidney cancer and melanoma.

Monoclonal Antibodies: Monoclonal antibodies are produced in a laboratory. The artificial antibodies are injected into the patient to seek out and disrupt cancer cell activities and to enhance the immune response against the cancer. (Before 2005, Rituximab (Rituxan) and trastuzumab (Herceptin), had been coded to immunotherapy. As of 2005 these two agents are coded to chemotherapy.)

Coding Instructions

1. Assign **code 00**
    a. When there is no information in the patient's medical record about immunotherapy AND
        i. It is known that radiation is not usually performed for this type and/or stage of cancer OR
        ii. There is no reason to suspect that the patient would have had immunotherapy.
    b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include immunotherapy
    c. Patient elects to pursue no treatment following the discussion of immunotherapy. Discussion does not equal a recommendation.
    d. Only information available is that the patient was referred to an oncologist. Referral does not equal a recommendation.
    e. Watchful waiting (prostate).
    f. Patient diagnosed at autopsy.

2. Assign **code 87**
    a. If the patient refused recommended immunotherapy.
    b. If the patient made a blanket refusal of all recommended treatment.
    c. If the patient refused all treatment before any was recommended.
3. Assign **code 99**
    a. When there is no documentation that immunotherapy was recommended or performed.
    b. Death certificate only.

Hematologic Transplant and Endocrine Procedures

This data item records systemic therapeutic procedure administered as part of the first-course of treatment. These procedures include bone marrow transplants (BMT) and stem cell harvests with rescue (stem cell transplant), endocrine surgery and/or radiation performed for hormonal effect (when cancer originates at another site), as well as combination of transplants and endocrine therapy.

Codes

00 None, transplant procedure or endocrine therapy was not a part of the first-course of therapy; not customary therapy for this cancer; diagnosed at autopsy only.

10 Bone marrow transplant, NOS. A bone marrow transplant procedure was administered as first-course therapy, but the type was not specified.
    11 Bone marrow transplant autologous
    12 Bone marrow transplant allogeneic

20 Stem cell harvest (stem cell transplant) as first-course therapy.

30 Endocrine surgery and/or endocrine radiation therapy as first-course therapy.

40 Combination of transplant procedure with endocrine surgery and/or endocrine radiation (Code 30 in combination with 10, 11, 12, or 20) as first-course therapy.

82 Transplant procedure and/or endocrine therapy was not recommended/administered because it was contraindicated due to patient's risk factors (comorbid conditions, advanced age, etc.).

85 Transplant procedures and/or endocrine therapy were not administered because the patient died prior to planned or recommended therapy.

86 Transplant procedures and/or endocrine therapy were not administered; it was recommended by the patient’s physician, but was not administered as part of first-course therapy. No reason was noted in the patient's record.

87 Transplant procedures and/or endocrine therapy were not administered; this treatment was recommended by the patient’s physician but was refused by the patient, a patient’s family member, or the patient’s guardian. The refusal was noted in the patient's record.

88 Transplant procedures and/or endocrine therapy was recommended, but it is unknown if it was administered.

99 It is unknown if a transplant procedure or endocrine therapy was recommended or administered because it is not stated in patient's record; death certificate only cases.

Definitions:

Bone marrow transplant (BMT): Procedure used to restore stem cells that were destroyed by chemotherapy and/or radiation. Replacing the stem cells allows the patient to undergo higher doses of chemotherapy.

BMT Allogeneic: Receives bone marrow or stem cells from a donor.
BMT Autologous: Uses the patient's own bone marrow and/or stem cells. The tumor cells are filtered out and the purified blood and stem cells are returned to the patient.

Note: Used for breast cancer, lymphoma, leukemia, aplastic anemia, myeloma, germ cell tumors, ovarian cancer, and small cell lung cancer.

Conditioning: High-dose chemotherapy with or without radiation administered prior to transplants such as BMT and stem cell to kill cancer cells. This conditioning also destroys normal bone marrow cells so the normal cells need to be replaced (rescue). The high dose chemotherapy is coded in the Chemotherapy field.

Hematopoietic Growth Factors: A group of substances that support hematopoietic (blood cell) colony formation. The group includes erythropoietin, interleukin-3, and colony-stimulating factors (CSFs). The growth-stimulating substances are ancillary drugs and not coded.

Non-Myeloablative Therapy: Uses immunosuppressive drugs pre- and post-transplant to ablate the bone marrow. These are not recorded as therapeutic agents.

Peripheral Blood Stem Cell Transplantation (PBSCT): Rescue that replaces stem cells after conditioning.

Rescue: Rescue is the actual BMT or stem cell transplant done after conditioning.

Stem Cells: Immature cells found in bone marrow, blood stream and umbilical cords. The stem cells mature into blood cells.

Coding Instructions

1. Assign **code 00**
   a. When there is no information in the patient's medical record about transplant procedure or endocrine therapy AND
      i. It is known that transplant procedure or endocrine therapy is not usually performed for this type and/or stage of cancer OR
      ii. There is no reason to suspect that the patient would have had transplant procedure or endocrine therapy.
   b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include transplant procedure or endocrine therapy
   c. Patient elects to pursue no treatment following the discussion of transplant procedure or endocrine therapy. Discussion does not equal a recommendation.

d. Only information available is that the patient was referred to an oncologist. Referral does not equal a recommendation.
e. Watchful waiting (CLL)
f. Patient diagnosed at autopsy

2. Assign **code 10** if the patient has "mixed chimera transplant (mini-transplant or non-myeloablative transplant). These transplants are a mixture of the patient's cells and donor cells.
3. **Codes 11 and 12** have priority over code 10 (BMT, NOS).
4. Assign **code 12** (allogeneic) for a syngeneic bone marrow transplant (from an identical twin) or for a transplant from any person other than the patient.
5. Assign **code 20** when the patient has a stem cell harvest followed by a rescue or reinfusion (stem cell transplant). If the patient does not have a rescue, code the stem cell harvest as 88, recommended, unknown if administered.
6. Assign **code 30** for endocrine radiation and/or surgery. Endocrine organs are testes and ovaries. Endocrine radiation and/or surgical procedures must be bilateral, or must remove the remaining paired organ for hormonal effect.
7. Assign **code 87**.
   a. If the patient **refused** recommended **transplant or endocrine procedure**.
   b. If the patient made a **blanket refusal** of all recommended treatment.
   c. If the patient **refused all treatment** before any was recommended.
8. Assign **code 99**
   a. When there is no documentation that transplant procedure or endocrine therapy was recommended or performed
   b. Death certificate only.

Other Therapy

Other Therapy identifies other treatment given that cannot be classified as surgery, radiation, systemic therapy, or ancillary treatment.

Codes

0 None
1 Other
2 Other-Experimental
3 Other-Double Blind
6 Other-Unproven
7 Refusal
8 Recommended, unknown if administered
9 Unknown

Coding Instructions

1. Assign **Code 0** when
   a. There is no information in the patient's medical record about other therapy AND
      i. It is known that other therapy is not usually performed for this type and/or stage of cancer OR
      ii. There is no reason to suspect that the patient would have had other therapy.

b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include other therapy
c. Patient elects to pursue no treatment following the discussion of other therapy. Discussion does not equal a recommendation.
d. Only information available is that the patient was referred for consideration of other therapy. Referral does not equal a recommendation.
e. Patient diagnosed at autopsy

2. Assign **code 1**
   a. Hematopoietic treatments such as: phlebotomy, transfusions, or aspirin
   b. Patient had cancer treatment that could not be assigned to the previous treatment fields (surgery, radiation, chemotherapy, immunotherapy, or systemic therapy)
3. Assign **Code 2** for any experimental or newly developed treatment that differs greatly from proven types of cancer therapy such as a clinical trial.

   Note: Hyperbaric oxygen has been used to treat cancer in clinical trials, but it is also used to promote tissue healing following head and neck surgeries. Do not code the administration of hyperbaric oxygen to promote healing as an experimental treatment.
4. Assign **code 3** when the patient is enrolled in a double blind clinical **trial**. When the trial is complete and the code is broken, review and recode the therapy.
5. Assign **code 6** for **unconventional** methods whether they are the single therapy or given in combination with conventional therapy.
6. Assign **code 8** when other therapy was recommended by the physician but there is no information that the treatment was given.
7. Assign **code 9**
   d. When there is no documentation that other therapy was recommended or performed
   e. Death certificate only.

The following explanations and definitions are quoted from the website for the National Center for Complimentary and Alternative Medicine (NCCAM). Complementary and alternative medicine, as defined by NCCAM, is a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine. While some scientific evidence exists regarding some CAM therapies, for most there are key questions that are yet to be answered through well-designed scientific studies - questions such as whether they are safe and whether they work for the diseases or medical conditions for which they are used.

- **Complementary** medicine is used **together with** conventional medicine. An example of a complementary therapy is using aromatherapy to help lessen a patient's discomfort following surgery.

- **Alternative** medicine is used **in place of** conventional medicine. An example of an alternative therapy is using a special diet to treat cancer instead of undergoing surgery, radiation, or chemotherapy that has been recommended by a conventional doctor.

See complete information on types of complementary and alternative medicine at
http://nccam.nih.gov/health/whatiscam/

Unconventional Methods

Cancell
Carnivora
Glyoxylide
Iscador
Koch synthetic antitoxins
Krebiozen
Laetrile
Malonide
Parabenzoquinone

Reference: NCI CancerNet articles on unconventional methods

Alternative and Complementary Therapies

Alternative Systems
- Acupuncture
- Ayurveda
- Environmental medicine
- Homeopathic medicine
- Natural Products
- Native American, Latin American, or traditional Oriental medicine

Bioelectromagnetic Applications
- Blue light treatment
- Electroacupuncture
- Magnetoresonance spectroscopy

Diet, Nutrition, Lifestyle
- Changes in lifestyle
- Diet
- Gerson Therapy
- Macrobiotics
- Megavitamins
- Nutritional Supplements

Herbal Medicine
- Ginger
- Ginkgo Biloba extract
- Ginseng root

Manual Healing
- Acupressure
- Biofield Therapeutics
- Massage therapy
- Relexology
- Zone therapy

Mind/Body Control
- Biofeedback
- Humor therapy
- Meditation
- Relaxation techniques
- Yoga

Pharmacological and Biological Treatments
- Anti-oxidizing agents
- Cell treatment
- Metabolic therapy
- Oxidizing agents

Reference: National Institutes of Health Office of Alternative Medicine

Date of Last Follow-up or Death

The date of last follow-up or death consists of eight digits recorded in the month, day, century, year format (MMDDCCYY) with 99 for unknown day or month and 9999 for unknown year. Follow-up is a very important aspect of the NJSCR reporting system. Follow-up is the annual monitoring of patients throughout their life to ascertain and calculate survival rates. Hospital programs approved by ACoS must update follow-up data annually. Information on vital status can be obtained from the medical records (patient may be readmitted), the patient's physician, contact letters, and telephone calls. Any follow-up information obtained must be reported to the NJSCR. For those registries that do not conduct active follow-up on a patient who is readmitted, the NJSCR must be notified with the date of admission. If a second/multiple primary is diagnosed, a separate abstract must be submitted electronically for the new primary. NJSCR is required to update the follow up information on all cases on an annual basis. The exception is carcinoma in situ of the cervix diagnosed on or after 1/1/1996. This data item records the date of last follow up or the date of death.

Follow-up must be submitted in paper form. This information must be submitted on printouts or in letter format. Please provide appropriate identification data (name, date of birth and social security number) so that files are updated accurately. If information is limited, an approximate date in time is acceptable.

Codes for Month

01 January
02 February
03 March
04 April
05 May
06 June
07 July
08 August
09 September
10 October
11 November
12 December
99 Unknown month

Codes for Day

01
02
03
..
..
31
99 Unknown day

Codes for Year

Code the four-digit year of follow up or death
Record 9999 for unknown year

Special Codes

99999999 Unknown date

Coding instructions

1. Code the date the patient was actually seen by the physician or contacted by the hospital registry as the follow up date. Do not code the date the follow up report was received.
2. Do not change the follow up date unless new information is available.
3. The field is associated with the patient, not the cancer, so all records (primary sites) for the same patient will have the same follow up date.

Follow-up Source

Identifies the source of the latest follow-up information.

0 Reported hospitalization
1 Readmission
2 Physician
3 Patient
4 Department of Motor Vehicles
5 Medicare/Medicaid file
7 Death certificate
8 Other
9 Unknown

Patient's Vital Status

Record the patient's vital status as of the date recorded in the "Date of Last Contact or Death" field. Use the most accurate information available.

1 Alive
0 Dead

Underlying Cause of Death

Record the cause of death listed on the death certificate by recording the underlying cause of death ICD code. This is the official underlying cause of death coded from the death certificate using ICD-7, ICDA-8, ICD-9, or ICD-10 codes.

Beginning for deaths in 1999, the United States agreed to code all deaths using the *International Statistical Classification of Diseases and Related Health Problems*, Tenth Revision (ICD-10). The ICD-10 codes have up to four characters: a letter followed by 2 or 3 digits.

Special Codes

0000	Patient alive at last follow-up
7777	State death certificate or listing not available
7797	State death certificate or listing available, but underlying cause of death not coded

Coding Instructions for ICD-10

Use the underlying cause of death as coded by a State Health Department even if the code seems to be in error.

1. Report the coded underlying cause of death code from another source such as NDI plus or state data exchange if the coded death certificate is not available.

2. If the coded underlying cause of death code is not on the death certificate and is not available from other sources, code 7797.

3. If neither the death certificate nor the coded underlying cause of death is available, code 7777.

   ***Example*:** Medical doctor states patient died, but death certificate not available (not on state death file, not available through federal or state agencies), code 7777.

4. Ignore (do not record) decimal points when copying codes.

5. The cause of death code is commonly four characters. Ignore (do not code) a fifth character if present.

6. Left justify the codes; if less than four characters, left justify and add a 9 to the right.

7. If the underlying cause of death code is not available, do not attempt to code the underlying cause of death unless you have a trained ICD-10 nosologist on staff or on consult.

The ICD-10 codes consist of four characters- a letter followed by two or three digits.

Examples:

UNDERLYING CAUSE OF DEATH	**ICD-10**	**CODE**
Cancer of the thyroid	C73	C739
Adenocarcinoma of stomach	C16.9	C169

Death Certificate-Only Cases

Death certificate-only cases contain information which was derived from a death certificate that was reported to the New Jersey Bureau of Vital Statistics with a cancer diagnosis. On a periodic basis the NJSCR electronically matches death certificates with a cancer diagnosis to its files to update vital status. This also serves as another source of case finding. Cases that are not linked to existing cases are termed as "death certificate-only" cases. "Death certificate-only" cases may include but not be limited to: malignancies diagnosed prior to a hospital registry date, prior to the NJSCR reference date October 1978, patients dead on arrival in the Emergency Department, or to patients who were erroneously coded as having a malignancy. On occasion, a patient may be on the "death certificate-only" list that has already been reported to the NJSCR but was not properly linked during the electronic matching process. Periodically, hospitals will be sent a listing of patients who have been identified as "death certificate-only" cases. Every effort should be made to locate information on these patients. Once the case is identified, it should be abstracted and then submitted electronically to the NJSCR.

Appendix A

Health Care Facility Codes

REPORTING FACILITY CODES

Each facility has two numerical identifiers. The five-digit codes were assigned by the New Jersey Department of Health and Senior Services, Division of Long Term Care Systems Development & Quality. The six-digit code programmed into your computer software was assigned by the American College of Surgeons (ACoS). In addition, each hospital has its unique three-letter File Abbreviation assigned by the New Jersey State Cancer Registry. The NJ File Abbreviation together with the ACoS six-digit code are to be used when submitting data electronically to the NJSCR.

Hospital	NJ Abbr	NJ Code	ACoS Code
Atlantic City Medical Center	ATC	10101	220040
Barnert Hospital	BMH	11601	221090
Bayonne Medical Center	BAY	10901	220070
Bayshore Community Health Services	BCH	11301	220395
Bergen Regional Medical Center	BPC	10201	222901
Bon Secours - St Mary's/Hoboken	SMH	10908	220390
Burdette Tomlin Memorial Hospital	BTM	10501	220217
Capital Health System/Fuld, Mercer	CAP	11104	000328
CentraState Medical Center	CMC	11302	220322
Chilton Memorial Hospital	CMH	11401	221175
Christ Hospital	CHR	10902	220420
Clara Maass Medical Center	CMM	10701	220758
Columbus Hospital	COL	10703	220760
Community Medical Center	COM	11501	221395
Cooper Health System	COO	10402	220190
Deborah Heart and Lung Center	DEB	20301	220160
East Orange General Hospital	EOG	10704	220240
Englewood Hospital and Medical Center	ENG	10202	220280
Greenville Hospital	GRE	10903	220440
Hackensack University Medical Center	HMC	10204	220360
Hackettstown Community Hospital	HCH	12101	220365
Holy Name Hospital	HNH	10205	221390
Hunterdon Medical Center	HUN	11001	220295
Irvington General Hospital	IRV	10706	220400
JFK Medical Center	KED	11201	220235
Kennedy Memorial Hospitals - UMC/Cherry Hill	KCH	10401	221345
Kennedy Memorial Hospitals - UMC/Stratford	KMS	10403	221345
Kennedy Memorial Hospitals - UMC/Washington	KMW	10802	000329
Kessler Memorial Hospital	WBK	10104	220373
Kimball Medical Center	KIM	11502	220540
Liberty Medical Center/Jersey City	JCM	10904	220435

Lourdes Medical Center of Burlington/Rancocas	ZMH	10303	220547
Meadowlands Hospital Medical Center	MHM	10906	221315
Memorial Hosp of Salem County	MHS	11702	221260
Meridian Health System/Jersey Shore Univ MC	JSM	11303	220740
Meridian Health System/Ocean Medical Ctr	MCO	11505	221170
Meridian Health System/Riverview Med Ctr	RMC	11305	221220
Monmouth Medical Center	MMC	11304	220560
Morristown Memorial Hospital	MMH	11403	220710
Mountainside Hospital	MOU	10708	220650
Muhlenberg Regional Medical Center	MUH	12004	221160
Newark Beth Israel Medical Center	NBI	10709	220820
Newton Memorial Hospital	NMH	11902	220990
Our Lady of Lourdes Medical Center	OLL	10404	220200
Overlook Hospital	OVH	12005	221370
Palisades Medical Center	PAL	10905	220425
Pascack Valley Hospital	PVH	10208	221618
Passaic Beth Israel Regional Medical Center	BIP	11602	221050
Patterson Army Community Hospital	PAH	21380	220310
Rahway Hospital	RAH	12006	221210
Raritan Bay Medical Center	RPA	11203	221140
Robert Wood Johnson University Hospital	RWJ	11202	220920
Robert Wood Johnson Univ Hosp at Hamilton	RWH	11101	221490
Roosevelt Hospital	ROO	21203	222905
Runnells Specialized Hospital	RUN	22001	222907
St. Barnabas Medical Center	SBM	10710	220800
St. Clare’s Hlth System/Denville, Dover,Sussex	DOV	11406	220225
St. Francis Medical Center/Trenton	SFM	11105	221480
St. James Hospital	SJN	10711	220880
St. Joseph’s Wayne Hospital	WGH	11603	221110
St. Joseph's Regional Medical Center	SJH	11605	221120
St. Mary's Hospital/Passaic	SMP	11606	221070
St. Michael's Medical Center	SMK	10713	220890
St. Peter's University Hospital	SPM	11205	220950
Shore Memorial Hospital	SHM	10103	221330
Somerset Medical Center	SOM	11802	221340
South Jersey Healthcare Regional Medical Ctr	SJM	10602	000068
Southern Ocean County Hosp	SOC	11504	220585
Trinitas Hospital/Williamson	SEH	12002	000025
Underwood Memorial Hospital	UND	10801	221630
Union Hospital	UNI	12003	221528
University Medical Center at Princeton	MCP	11103	221190
University of Med and Dentistry of NJ (UMDNJ)	UMD	10702	220785
VA NJ Health Care System	EOV	20778	220245

Valley Hospital	VAL	10211	221235
Virtua Mem of Burlington County (Fox Chase)	MRC	10301	220730
Virtua/West Jersey Hospitals	WJH	10406	220600
Warren Hospital	WAR	12102	221145

Free-Standing Radiation Facilities		09500	
Ambulatory Surgical Centers		09600	
Free-Standing Clinics & Physicians	DSC	09700	999993
Dentists		09800	
Laboratories & Imaging Centers	LAB	09900	999995

Appendix B

SEER Geocodes

For Coding Place of Birth and Place of Death

APPENDIX B

SEER GEOCODES

For Coding Place of Birth and Place of Death

APPENDIX B

SEER GEOCODES

For Coding Place of Birth and Place of Death

Table of Contents

CONTINENTAL UNITED STATES AND HAWAII

000 United States

001 New England States
- 002 Maine
- 003 New Hampshire
- 004 Vermont
- 005 Massachusetts
- 006 Rhode Island
- 007 Connecticut
- 008 New Jersey

010 North Mid-Atlantic States
- 011 New York
- 014 Pennsylvania
- 017 Delaware

020 South Mid-Atlantic States
- 021 Maryland
- 022 District of Columbia
- 023 Virginia
- 024 West Virginia
- 025 North Carolina
- 026 South Carolina

030 Southeastern States
- 031 Tennessee
- 033 Georgia
- 035 Florida
- 037 Alabama
- 039 Mississippi

040 North Central States
- 041 Michigan
- 043 Ohio
- 045 Indiana
- 047 Kentucky

050 Northern Midwest States
- 051 Wisconsin
- 052 Minnesota
- 053 Iowa
- 054 North Dakota
- 055 South Dakota
- 056 Montana

060 Central Midwest States
- 061 Illinois
- 063 Missouri
- 065 Kansas
- 067 Nebraska

070 Southern Midwest States
- 071 Arkansas
- 073 Louisiana
- 075 Oklahoma
- 077 Texas

080 Mountain States
- 081 Idaho
- 082 Wyoming
- 083 Colorado
- 084 Utah
- 085 Nevada
- 086 New Mexico
- 087 Arizona

090 Pacific Coast States
- 091 Alaska
- 093 Washington
- 095 Oregon
- 097 California
- 099 Hawaii

UNITED STATES POSSESSIONS

When SEER geocodes were originally assigned during the 1970s, the United States owned or controlled islands in the Pacific. Since then many of these islands have either been given their independence or had control turned over to another country. In order to maintain consistent information over time, these islands are still to be coded to the original codes. Earlier designations are listed in parentheses.

100 Atlantic/Caribbean Area
- 101 Puerto Rico
- 102 U.S. Virgin Islands
- 109 Other Atlantic/Caribbean Area

110 Canal Zone

120 Pacific Area
- 121 American Samoa
- 122 Kiribati (Canton and Enderbury Islands, Gilbert Islands, Southern Line Islands, Phoenix Islands)
- 123 Micronesia [Federated States of] (Caroline Islands, Trust Territory of Pacific Islands)
- 124 Cook Islands (New Zealand)
- 125 Tuvalu (Ellice Islands)
- 126 Guam
- 127 Johnston Atoll
- 129 Mariana Islands (Trust Territory of Pacific Islands) Northern Mariana Islands
- 131 Marshall Islands (Trust Territory of Pacific Islands)
- 132 Midway Islands
- 133 Nampo-Shoto, Southern
- 134 Ryukyu Islands (Japan)
- 135 Swan Islands
- 136 Tokelau Islands (New Zealand)
- 137 Wake Island
- 139 Palau (Trust Territory of Pacific Islands)

NORTH AND SOUTH AMERICA, EXCLUSIVE OF THE UNITED STATES AND ITS POSSESSIONS

210 Greenland

220 Canada
- 221 Maritime provinces
  - Labrador
  - New Brunswick
  - Newfoundland
  - Nova Scotia
  - Prince Edward Island
- 222 Quebec
- 223 Ontario
- 224 Prairie Provinces
  - Alberta
  - Manitoba
  - Saskatchewan
- 225 Northwest Territories
  - Yukon Territory
- 226 British Columbia
- 227 Nunavut (Nunavut became an official Territory of Canada on April 1, 1999)

230 Mexico

240 North American Islands
- 241 Cuba
- 242 Haiti
- 243 Dominican Republic
- 244 Jamaica
- 245 Other Caribbean Islands
  - Anguilla
  - Antigua and Barbuda
  - Antilles, NOS
  - Aruba
  - Barbados
  - British Virgin Islands
  - British West Indies, NOS
  - Caribbean, NOS
  - Cayman Islands
  - Curacao
  - Dominica
  - French West Indies
  - Grenada
  - Grenadines, The
  - Guadeloupe
  - Leeward Island, NOS
  - Martinique
  - Montserrat
  - Netherlands Antilles
  - St. Christopher-Nevis
  - St. Kitts
  - St. Lucia
  - St. Vincent and The Grenadines
  - Trinidad and Tobago
  - Turks Islands Antilles, NOS
  - British West Indies, NOS
  - Carribean, NOS
- 245 Other Caribbean Islands, continued
  - Leeward islands, NOS
  - West Indies, NOS
  - Windward Islands, NOS
- 246 Bermuda
- 247 Bahamas, The
- 249 St. Pierre and Miquelon

250 Central America
- 251 Guatemala
- 252 Belize (British Honduras)
- 253 Honduras
- 254 El Salvador
- 255 Nicaragua
- 256 Costa Rica
- 257 Panama

260 North America, NOS

265 Latin America, NOS

300 South America, NOS
- 381 Colombia
- 321 Venezuela
- 331 Guyana (British Guiana)
- 332 Suriname (Dutch Guiana)
  Netherlands Guiana
- 333 French Guiana
- 341 Brazil
- 345 Ecuador
  Galapagos Islands
- 351 Peru
- 355 Bolivia
- 361 Chile
- 365 Argentina
- 371 Paraguay
- 375 Uruguay

380 South American Islands
- 381 Falkland Islands

EUROPE

former or alternative names are in parentheses

Europe, NOS (See code 499) *

400 United Kingdom, NOS
- 401 England
  - Channel Islands
  - Guernsey
  - Isle of Man
  - Jersey
- 402 Wales
- 403 Scotland
  - Orkney Islands
  - Shetland Islands
- 404 Northern Ireland (Ulster)

410 Ireland (Eire)
- Ireland, NOS
- Republic of Ireland

420 Scandinavia
- Lapland, NOS
- 421 Iceland
- 423 Norway
  - Svalbard
- 425 Denmark
  - Faroe (Faeroe) Islands
- 427 Sweden
- 429 Finland

430 Germanic Countries
- 431 Germany
  - East Germany including East Berlin
  - West Germany including West Berlin
  - Federal Republic of Germany
  - German Democratic Republic
  - Germany, East
  - Germany, Federal Republic of
  - Germany, West
- 432 Netherlands
  - Holland
- 433 Belgium
- 434 Luxembourg
- 435 Switzerland
- 436 Austria
- 437 Liechtenstein

440 Romance-language Countries
- 441 France
  - Corsica
  - Monaco
- 443 Spain
  - Andorra
  - Balearic Islands
  - Canary Islands

* *Effective cases diagnosed 1/1/1992.*

- 445 Portugal
  - Azores
  - Cape Verde Islands
  - Madeira Islands
- 447 Italy
  - San Marino
  - Sardinia
  - Sicily
  - Vatican City (Holy See)
- 449 Romania

450 Slavic Countries
- 451 Poland
- 452 (former)Czechoslovakia region
  - Bohemia
  - Czech Republic
  - Moravia
  - Slovak Republic
  - Slovakia
- 453 (former) Yugoslavia region
  - Bosnia-Herzogovina
  - Croatia
  - Dalmatia
  - Jugoslavia
  - Macedonia
  - Montenegro
  - Serbia
  - Slavonia
  - Slovenia
- 454 Bulgaria
- 455 Russia
  - Russian Federation
  - (former) U.S.S.R.
  - Russia, NOS
  - (Russian S.F.S.R.)

456 Ukraine and Moldova
(Bessarabia)
Moldavia
(Moldavian S.S.R.)
(Ukranian S.S.R.)
457 Belarus
(Byelorussian S.S.R.)
(White Russia)
458 Estonia (Estonian S.S.R.)
459 Latvia (Latvian S.S.R.)
461 Lithuania
(Lithuanian S.S.R.)
463 Baltic Republic(s), NOS
(Baltic States, NOS)

470 Other mainland Europe
471 Greece
Crete
475 Hungary
481 Albania
485 Gibraltar

490 Other Mediterranean Islands
491 Malta
495 Cyprus

499 Europe, NOS*
Central Europe, NOS
Eastern Europe, NOS
Northern Europe, NOS
Southern Europe, NOS
Western Europe, NOS

** Effective cases diagnosed 1/1/1992.*

AFRICA

500 Africa, NOS
Central Africa, NOS
Equatorial Africa, NOS

510 North Africa, NOS
511 Morocco
513 Algeria
515 Tunisia
517 Libya
(Cyrenaica)
(Tripoli)
(Tripolitania)
519 Egypt (United Arab Republic)

520 Sudanese Countries
Burkina Faso (Upper Volta)
Chad
Mali
Mauritania
Niger
Sudan (Anglo-Egyptian Sudan)
Western (Spanish) Sahara

530 West Africa
French West Africa, NOS
531 Nigeria
539 Other West African Countries
Benin (Dahomey)
Cameroon (Kameroon)
Central African Republic (French Equatorial Africa)
Cote d'Ivoire (Ivory Coast)
Congo (Congo-Brazzaville, French Congo)
Equatorial Guinea (Spanish Guinea) (Bioko {Fernando Poo}, Rio Muni)
Gabon
Gambia, The
Ghana
Guinea
Guinea Bissau (Portuguese Guinea)
Liberia
Senegal
Sierra Leone
Togo

540 South Africa
541 Zaire (Congo-Leopoldville, Belgian Congo, Congo Kinshasa)
543 Angola (Sao Tome, Principe, Cabinda)
545 Republic of South Africa (Bophuthatswana, Cape Colony, Ciskei, Natal, Free State {Orange Free State}, Transkei, Transvaal, Venda)
Botswana (Bechuanaland)
Lesotho (Basutoland)
Namibia (South West Africa)
Swaziland
Union of South Africa

547 Zimbabwe (Rhodesia, Southern Rhodesia)
549 Zambia (Northern Rhodesia)
551 Malawi (Nyasaland)
553 Mozambique
555 Madagascar (Malagasy Republic)

570 East Africa
571 Tanzania (Tanganyika, Tanzanyika, Zanzibar)
573 Uganda
575 Kenya
577 Rwanda (Ruanda)
579 Burundi (Urundi)
581 Somalia (Somali Republic, Somaliland)
583 Djibouti (French Territory of the Afars and Issas, French Somaliland)
585 Ethiopia (Abyssinia)
Eritrea

580 African Coastal Islands (previously included in 540)
Comoros
Mauritius
Mayotte
Reunion
St. Helena
Seychelles

** Effective cases diagnosed 1/1/1992*

ASIA

600 Asia, NOS*

610 Near East
Mesopotamia, NOS
611 TurkeyAnatolia
Armenia (Turkey)
Asia Minor, NOS

620 Asian Arab Countries
Iraq-Saudi Arabia Neutral Zone
621 Syria
623 Lebanon
625 Jordan (Trans-Jordan, former Arab Palestine)
627 Iraq
629 Arabian Peninsula
Bahrain
Kuwait
Oman
Muscat
Persian Gulf States, NOS
Qatar
Saudi Arabia
United Arab Emirates (Trucial States)
Yemen (Aden, People's Democratic Republic of Yemen, Southern Yemen)
631 Israel and former Jewish Palestine
Gaza
Palestine (Palestinian National Authority--PNA)
Palestine, NOS
West Bank
633 Caucasian Republics of the former U.S.S.R.
Armenia
Azerbaijan (Nagorno-Karabakh)
Azerbaizhan S.S.R
Georgia
634 Other Asian Republics of the former U.S.S.R.
Kazakhstan (Kazakh S.S.R.)
Kyrgystan (Kirghiz S.S.R., Kyrgyz)
Tajikistan (Tadzhik S.S.R.)
Turkmenistan (Turkmen S.S.R.)
Uzbekistan (Uzbek S.S.R.)
637 Iran (Persia)
638 Afghanistan
639 Pakistan (West Pakistan)
640 Mid-East Asia, NOS
Maldives
641 India
Andaman Islands
643 Nepal
Bhutan
Sikkim
645 Bangladesh (East Pakistan)
647 Sri Lanka (Ceylon)
649 Myanmar (Burma)

650 Southeast Asia
651 Thailand (Siam)

660 Indochina
- 661 Laos
- 663 Cambodia
  - Kampuchea
- 665 Vietnam (Tonkin, Annam, Cochin China)
- 671 Malaysia
  - Brunei
  - Malay Peninsula
  - North Borneo
  - Singapore
- 673 Indonesia (Dutch East Indies)
  - Borneo
  - Java
  - New Guinea, except Australian and North East
  - Sumatra
- 675 Philippines (Philippine Islands)

680 East Asia
- 681 China, NOS
- 682 China (People's Republic of China)
- 683 Hong Kong
- 684 Taiwan (Formosa, Republic of China)
- 685 Tibet
- 686 Macao (Macau)
- 691 Mongolia
- 693 Japan
- 695 Korea
  - North Korea
  - South Korea

* *Effective cases diagnosed 1/1/1992.*

AUSTRALIA AND OCEANIA

711 Australia
- Cartier Islands
- Cocos (Keeling) Islands
- New Guinea, Australian
- New Guinea, North East
- Norfolk Island
- Papau New Guinea

715 New Zealand
- Niue

720 Pacific Islands ~
- Oceania, NOS
- Polynesia, NOS

721 Melanesian Islands
- Fiji
- Futuna
- New Hebrides
- Solomon Islands
- Vanuatu
- Wallis

723 Micronesian Islands ~
- Christmas Island
- Nauru

725 Polynesian Islands ~
- French Polynesia
- New Caledonia
- Pitcairn Islands
- Samoa, Western
- Tonga
- Western Samoa

750 Antarctica

~ Except possessions of the U.S.A.

PLACE OF BIRTH UNKNOWN

998 Place of Birth stated not to be in United States, but no other information available

999 Place of Birth unknown

References: *CIA World Factbook,* 1995.
U.S. Bureau of the Census Place of Birth Technical Documentation, 1997.

ALPHABETICAL LISTING
** Effective cases diagnosed 1/1/1992.*

A

585 Abyssinia
629 Aden
583 Afars and Issas
638 Afghanistan
500 Africa
570 Africa, East
510 Africa, North
540 Africa, South
545 Africa, South West
530 Africa, West
580 African Coastal Islands (previously included in 540)
037 Alabama
091 Alaska
481 Albania
224 Alberta
513 Algeria
250 America, Central
265 America, Latin
260 America, North (use a more specific term; see also North America)
300 America, South
121 American Samoa
611 Anatolia
641 Andaman Islands
443 Andorra
520 Anglo-Egyptian Sudan
543 Angola
245 Anguilla
665 Annam
750 Antarctica
245 Antigua
245 Antilles, NOS
245 Antilles, Netherlands
625 Arab Palestine (former)
629 Arabia, Saudi
629 Arabian Peninsula
365 Argentina
087 Arizona
071 Arkansas
611 Armenia (Turkey)
633 Armenia (U.S.S.R.)
245 Aruba
600 Asia, NOS*
680 Asia, East
640 Asia, Mid-East
611 Asia Minor, NOS

610 Asia, Near-East
650 Asia, Southeast

620 Asian Arab Countries
634 Asian Republics of the former U.S.S.R.
109 Atlantic/Caribbean area, other U.S. possessions
100 Atlantic/Caribbean area, U.S. possessions
711 Australia
711 Australian New Guinea
436 Austria
633 Azerbaijan
633 Azerbaizhan S.S.R.
445 Azores

B

247 Bahamas, The
629 Bahrain
443 Balearic Islands
463 Baltic Republic(s), NOS
463 Baltic States, NOS
645 Bangladesh
245 Barbados
245 Barbuda
545 Basutoland
431 Bavaria
545 Bechuanaland
457 Belarus
541 Belgian Congo
433 Belgium
252 Belize
539 Benin
246 Bermuda
456 Bessarabia
643 Bhutan
539 Bioko (Fernando Poo)
452 Bohemia
355 Bolivia
545 Bophuthatswana
673 Borneo
453 Bosnia-Herzogovina
545 Botswana
341 Brazil
226 British Columbia
331 British Guiana
252 British Honduras
245 British Virgin Islands
245 British West Indies, NOS
671 Brunei

454 Bulgaria
520 Burkina Faso (Upper Volta)
649 Burma (see Myanmar)
579 Burundi
457 Byelorussian S.S.R.

C

543 Cabinda
245 Caicos Islands
097 California
663 Cambodia
539 Cameroon
220 Canada
110 Canal Zone
443 Canary Islands
122 Canton Islands
545 Cape Colony
445 Cape Verde Islands
245 Caribbean, NOS
245 Caribbean Islands, other
123 Caroline Islands
711 Cartier Islands
633 Caucasian Republics of the former U.S.S.R.
245 Cayman Islands
500 Central Africa, NOS
539 Central African Republic
250 Central America
499 Central Europe, NOS
060 Central Midwest States
647 Ceylon (see Sri Lanka)
520 Chad
401 Channel Islands (British)
361 Chile
681 China, NOS
665 China, Cochin
682 China, People's Republic of
684 China, Republic of
723 Christmas Island
545 Ciskei
665 Cochin China
711 Cocos (Keeling) Islands
381 Colombia
083 Colorado
580 Comoros
226 Columbia, British
022 Columbia, District of
539 Congo, NOS
539 Congo-Brazzaville
541 Congo-Leopoldville
541 Congo, Belgian
539 Congo, French

541 Congo Kinshasa
007 Connecticut
124 Cook Islands
441 Corsica
256 Costa Rica
539 Cote d'Ivoire (Ivory Coast)
471 Crete
453 Croatia
241 Cuba
245 Curacao
495 Cyprus
517 Cyrenaica
452 Czechoslovakia
452 Czech Republic

D

539 Dahomey
453 Dalmatia
017 Delaware
425 Denmark
022 District of Columbia
583 Djibouti
449 Dobruja
245 Dominica
243 Dominican Republic
673 Dutch East Indies
332 Dutch Guiana

E

570 East Africa
680 East Asia
431 East Germany
673 East Indies, Dutch
645 East Pakistan
499 Eastern Europe, NOS
345 Ecuador
519 Egypt
410 Eire
254 El Salvador
125 Ellice Islands
122 Enderbury Islands
401 England
122 Enterbury Islands
500 Equatorial Africa, NOS
539 Equatorial Guinea (Spanish Guinea)
585 Eritrea
458 Estonia
458 Estonian S.S.R. (Estonia)
585 Ethiopia

499 Europe, NOS*
470 Europe, other mainland

F

425 Faroe (Faeroe) Islands
381 Falkland Islands
431 Federal Republic of Germany
123 Federated States of Micronesia
539 Fernando Poo
721 Fiji
429 Finland
035 Florida
684 Formosa
441 France
545 Free State (Orange Free State)
539 French Congo
333 French Guiana
725 French Polynesia
583 French Somaliland
530 French West Africa, NOS
245 French West Indies
721 Futuna

G

539 Gabon
345 Galapagos Islands
539 Gambia, The
631 Gaza Strip
033 Georgia (U.S.A.)
633 Georgia (U.S.S.R.)
431 German Democratic Republic
430 Germanic Countries
431 Germany
431 Germany, East
431 Germany, Federal Republic of
431 Germany, West
539 Ghana
485 Gibraltar
122 Gilbert Islands
471 Greece
210 Greenland
245 Grenada
245 Grenadines, The
245 Guadaloupe
126 Guam
251 Guatamala
401 Guernsey
331 Guiana, British
332 Guiana, Dutch
333 Guiana, French

539 Guinea
539 Guinea-Bissau (Portuguese Guinea)
539 Guinea, Equatorial
—— Guinea, New (see New Guinea)
539 Guinea, Portuguese
331 Guyana

H

242 Haiti
099 Hawaii
432 Holland
253 Honduras
252 Honduras, British
683 Hong Kong
475 Hungary

I

421 Iceland
081 Idaho
061 Illinois
641 India
045 Indiana
673 Indies, Dutch East
660 Indochina
673 Indonesia
053 Iowa
637 Iran
627 Iraq
620 Iraq-Saudi Arabian Neutral Zone
410 Ireland (Eire)
410 Ireland, NOS
404 Ireland, Northern
410 Ireland, Republic of
401 Isle of Man
631 Israel
583 Issas
447 Italy
539 Ivory Coast

J

244 Jamaica
423 Jan Mayen
693 Japan
673 Java
401 Jersey
631 Jewish Palestine
127 Johnston Atoll
625 Jordan

453 Jugoslavia

K

539 Kameroon
663 Kampuchea
065 Kansas
634 Kazakh S.S.R.
634 Kazakhstan
047 Kentucky
575 Kenya
634 Kirghiz S.S.R.
122 Kiribati
695 Korea
695 Korea, North
695 Korea, South
629 Kuwait
634 Kyrgystan
634 Kyrgyz

L

221 Labrador
661 Laos
420 Lapland, NOS
265 Latin America, NOS
459 Latvia
459 Latvian S.S.R. (Latvia)
623 Lebanon
245 Leeward Island, NOS
545 Lesotho
539 Liberia
517 Libya
437 Liechtenstein
122 Line Islands, Southern
461 Lithuania
461 Lithuanian S.S.R. (Lithuania)
073 Louisiana
434 Luxembourg

M

686 Macao
686 Macau
453 Macedonia
555 Madagascar
445 Madeira Islands
002 Maine
555 Malagasy Republic
551 Malawi
671 Malay Peninsula
671 Malaysia

640 Maldives
520 Mali
491 Malta
224 Manitoba
129 Mariana Islands
221 Maritime Provinces, Canada
131 Marshall Islands
245 Martinique
021 Maryland
005 Massachusetts
520 Mauritania
580 Mauritius
580 Mayotte
490 Mediterranean Islands, Other
721 Melanesian Islands
610 Mesopotamia, NOS
230 Mexico
041 Michigan
123 Micronesian Islands
640 Mid-East Asia
132 Midway Islands
052 Minnesota
249 Miquelon
039 Mississippi
063 Missouri
456 Moldavia
456 Moldavian S.S.R.
456 Moldova
441 Monaco
691 Mongolia
056 Montana
453 Montenegro
245 Montserrat
452 Moravia
511 Morocco
080 Mountain States
553 Mozambique
629 Muscat
649 Myanmar (see Burma)

N

545 Namibia
133 Nampo-shoto, Southern
545 Natal
723 Nauru
610 Near-East Asia
067 Nebraska
643 Nepal
432 Netherlands
245 Netherlands Antilles
332 Netherlands Guiana

085 Nevada
245 Nevis
221 New Brunswick
725 New Caledonia
001 New England
673 New Guinea, except Australian and North East
711 New Guinea, Australian
711 New Guinea, North East
003 New Hampshire
721 New Hebrides
008 New Jersey
086 New Mexico
011 New York
715 New Zealand
221 Newfoundland
255 Nicaragua
520 Niger
531 Nigeria
715 Niue
510 North Africa, NOS
260 North America, NOS (use more specific term if possible)
240 North American Islands
671 North Borneo (Malaysia)
025 North Carolina
040 North Central States
054 North Dakota
711 North East New Guinea
695 North Korea
010 North Mid-Atlantic States
499 Northern Europe, NOS
404 Northern Ireland
129 Northern Mariana Islands
050 Northern Midwest States
549 Northern Rhodesia
711 Norfolk Island
225 Northwest Territories (Canada)
423 Norway
998 Not United States, NOS
221 Nova Scotia
227 Nunavut
551 Nyasaland

O

720 Oceania
043 Ohio
075 Oklahoma
629 Oman
223 Ontario
545 Orange Free State
095 Oregon

403 Orkney Islands

P

120 Pacific area, U.S. possessions
720 Pacific Islands
123 Pacific Islands, Trust Territory of the (code to specific islands if possible)
090 Pacific Coast States
639 Pakistan
645 Pakistan, East
639 Pakistan, West
139 Palau (Trust Territory of the Pacific Islands)
625 Palestine, Arab
631 Palestine, Jewish
631 Palestine, NOS
631 Palestinian National Authority--PNA
257 Panama
711 Papua New Guinea
371 Paraguay
014 Pennsylvania
629 People's Democratic Republic of Yemen
682 People's Republic of China
637 Persia
629 Persian Gulf States, NOS
351 Peru
675 Philippine Islands
675 Philippines
122 Phoenix Islands
725 Pitcairn Islands
451 Poland
725 Polynesian Islands
445 Portugal
539 Portuguese Guinea
224 Prairie Provinces, Canada
221 Prince Edward Island
543 Principe
101 Puerto Rico

Q

629 Qatar
222 Quebec

R

684 Republic of China
545 Republic of South Africa
580 Reunion
006 Rhode Island
547 Rhodesia

549 Rhodesia, Northern
547 Rhodesia, Southern
539 Rio Muni
440 Romance-language Countries
449 Romania
449 Roumania
577 Ruanda
449 Rumania
455 Russia, NOS
457 Russia, White
455 Russian Federation (former U.S.S.R.)
455 Russian S.F.S.R.
577 Rwanda
134 Ryukyu Islands (Japan)

S

520 Sahara, Western (Spanish)
121 Samoa, American
725 Samoa, Western
245 St. Christopher-Nevis
580 St. Helena
245 St. Kitts
245 St. Lucia
249 St. Pierre
245 St. Vincent
447 San Marino
543 Sao Tome
447 Sardinia
224 Saskatchewan
629 Saudi Arabia
420 Scandinavia
403 Scotland
539 Senegal
453 Serbia
580 Seychelles
403 Shetland Islands
651 Siam
447 Sicily
539 Sierra Leone
643 Sikkim
671 Singapore
450 Slavic Countries
453 Slavonia
452 Slovak Republic
452 Slovakia
453 Slovenia
721 Solomon Islands
581 Somali Republic
581 Somalia
581 Somaliland

583 Somaliland, French
540 South Africa
545 South Africa, Republic of
545 South Africa, Union of
300 South America
380 South American Islands
026 South Carolina
055 South Dakota
695 South Korea
020 South Mid-Atlantic States
545 South West Africa
650 Southeast Asia
030 Southeastern States
499 Southern Europe, NOS
122 Southern Line Islands
070 Southern Midwest States
133 Southern Nampo-shoto
547 Southern Rhodesia
629 Southern Yemen
—— Soviet Union (see individual republics)
443 Spain
520 Spanish Sahara
647 Sri Lanka (see Ceylon)
520 Sudan (Anglo-Egyptian Sudan)
520 Sudanese Countries
673 Sumatra
332 Suriname
423 Svalbard
135 Swan Islands
545 Swaziland
427 Sweden
435 Switzerland
621 Syria

T

634 Tadzhik S.S.R.
684 Taiwan
634 Tajikistan
571 Tanzania
571 Tanganyika
571 Tanzanyika
031 Tennessee
077 Texas
651 Thailand (Siam)
685 Tibet
245 Tobago
539 Togo
136 Tokelau Islands
725 Tonga
665 Tonkin

625 Trans-Jordan
545 Transkei
545 Transvaal
449 Transylvania
245 Trinidad
517 Tripoli
517 Tripolitania
629 Trucial States
515 Tunisia
611 Turkey
634 Turkmen S.S.R.
634 Turkmenistan
245 Turks Islands
125 Tuvalu

U

573 Uganda
456 Ukraine
456 Ukranian S.S.R.
404 Ulster
545 Union of South Africa
—— Union of Soviet Socialist Republics (U.S.S.R.) (see individual republics)
629 United Arab Emirates
519 United Arab Republic
400 United Kingdom
000 United States
102 U.S. Virgin Islands
999 Unknown
520 Upper Volta
375 Uruguay
579 Urundi
084 Utah
634 Uzbekistan
634 Uzbek S.S.R.

V

721 Vanuatu
447 Vatican City
545 Venda
321 Venezuela
004 Vermont
665 Vietnam
245 Virgin Islands (British)
102 Virgin Islands (U.S.)
023 Virginia

W

137 Wake Island
402 Wales
449 Wallachia
721 Wallis
093 Washington (state)
022 Washington D.C.
530 West Africa, NOS
539 West African Countries, other
631 West Bank
431 West Germany
245 West Indies, NOS (see also individual islands)
639 West Pakistan
024 West Virginia
499 Western Europe, NOS
520 Western (Spanish) Sahara
725 Western Samoa
457 White Russia
245 Windward islands
051 Wisconsin
082 Wyoming

Y

629 Yemen
629 Yemen, People's Democratic Republic of
453 Yugoslavia (former Yugoslavia region)
225 Yukon Territory

Z

541 Zaire
549 Zambia
571 Zanzibar
547 Zimbabwe

Appendix C

Text Fields

Text Fields

Text documentation is an essential component of a complete electronic abstract and is utilized for quality assurance activities and special studies. Text is needed to justify coded values and to document supplemental information.

The following tables provide instructions, examples and the maximum field length (number of characters) the NJSCR will accept electronically based on NAACCR version 10.2.

General Guidelines:

- Prioritize information
- Text automatically generated from coded data is not acceptable
- If information is missing, state that it is missing
- Do not repeat information
- Do not include irrelevant information
- Additional comments can be added to empty text fields, use symbols to indicate this has been done

NJSCR Text Fields	Descriptioon	Max Field Length
Text-DX Proc-Lab Tests	Document pertinent information from laboratory reports other then cytology or histology. Record both positive and negative findings. Include applicable studies such as: tumor markers, special studies, serum and urine electrophoresis, flow cytometry, etc.	250
Text-DX Proc-OP	Document pertinent information and dates for surgical procedures that provide information useful for staging and to support treatment codes. Include number of lymph nodes removed, tumor size, documentation of residual tumor, evidence of invasion in surrounding tissue.	250
Text-DX-Proc-Path	Document a synopsis of pertinent information from cytology and histopathology reports. Record date of procedure, type of specimen, histology and grade, tumor size, extent of tumor spread, involvement of resection margins, total number of lymph nodes removed and total number involved with tumor. Record both positive and negative findings. Record any additional comments or addendum information.	250
Text-DX Proc-PE	Document pertinent information from the history and physical as it relates to the cancer diagnosis. Include dates, age, sex, race. Record any information related to clinical findings, tumor size, palpable lymph nodes, impression, and treatment plans.	200
Text-DX Proc-Scopes	Document pertinent information as it relates to endoscopic exams that provide information for diagnosis, staging and treatment. Include dates, and any information related to tumor size, tumor location, lymph nodes and histology. Record positive and negative findings.	250
Text-DX Proc-X-ray/Scan	Document pertinent information and dates from all x-rays, scans, and other imaging studies that may provide information regarding staging. Please include any information related to primary site, tumor, tumor size, location, lymph nodes. Record both positive and negative findings.	250
Text-Histology Title	Document information regarding histology, behavior, type, and grade to ensure that the text agrees with the coded values.	40
Text-Primary Site Title	Document information regarding primary site and laterality of the tumor to ensure that the text agrees with the coded values.	40
Text-Remarks	This area is for overflow text, problematic coding areas, information on sequencing cancers etc. Any additional information that is pertinent to the case.	350
Text-Staging	This area is for documenting additional text pertinent to staging that has not been recorded in any of the other text fields.	300
Text- Usual Industry	This field is utilized to record information about the patient's usual business/industry.	40
Text-Usual Occupation	Record the patient's usual occupation also known as usual type of work.	40

Appendix D

Reference and Resources

STAGING AND CODING MANUALS BY EDITION AND DATE IMPLEMENTED

International Classification of Diseases for Oncology

First Edition	1976 - 1991
Second Edition	1992 - 2000
Third Edition	2001 +

American Joint Committee on Cancer TNM Staging System

Second Edition	1983 - 1988
Third Edition	1989 - 1992
Fourth Edition	1993 - 1997
Fifth Edition	1998 - 2002
Sixth Edition	2003 +

SEER Extent of Disease Manual (not required in NJ until 2000)

First Edition	1988 - 1991
Second Edition	1992 - 1997
Third Edition	1998 - 2003

Summary Staging

Summary Staging Guide	1977 - 2000
SEER Summary Staging Manual 2000	2001 -

Collaborative Staging System 2004 -

Data Collection

Data Acquisition Manual	1988-1994
1st revision 10/89	
2nd revision 10/90	
Data Acquisition Manual, revised	1994-1995

Registry Operations and Data Standards

(ROADS Manual)	1996 - 2002
2-digit surgery codes	1988 - 1997
"New" surgery codes	1998 - 2002

Facility Oncology Registry Data Standards

(FORDS)	2003
FORDS revised for 2004	2004-

SEER Program Code Manual

First Edition	1988 - 1991
Second Edition	1992 - 1997
Third Edition	1998 - 2003

SEER Program Coding and Staging Manual 2004 2004-

SEER Book 8 Antineoplastic drugs	1981- 2004
SEER*Rx, Antineoplastic drug database http://www.seer.cancer.gov/seerrx.	2005 -

Cancer Program Standards

Cancer Program Manual 1986	1986 - 1990
Cancer Program Manual 1991	1991 - 1995
Cancer Program Standards (Volume 1)	1996 - 6/2003
Revised Cancer Program Standards (Volume 1)	7/2003 -

Appendix E

NJSCR Regulations and Reportable List

CANCER REPORTING

CANCER REGISTRY STATUTE

26:2-104 Legislative findings and declaration

The Legislature hereby finds and declares:

(a) That New Jersey is currently suffering from the highest overall mortality rates for cancer in the Nation;

(b) That certain forms of cancer are now believed to be attributable to environmental factors which, if controlled, can significantly reduce incidence in this State;

(c) That more complete and more precise statistical data are necessary to determine the correlations between cancer incidence and possible environmental factors and to evaluate cancer treatment and prevention measures that are currently in progress; and,

(d) That a cancer registry would thus provide a vital foundation for a concerted State effort to reduce the incidence of environmentally related cancer in this State.

L.1997, c266, s.1.

26:2-105 Establishment and maintenance; Inclusions

The Department of Health and Senior Services shall establish and maintain an up-to-date registry which shall include a record of cases of cancer and specified cases of tumorous or precancerous disease that occur in New Jersey, and such information concerning these cases as it shall deem necessary and appropriate in order to conduct thorough and complete epidemiologic surveys of cancer and cancer-related diseases in this State and to apply appropriate preventive and control measures.

L.1977, c.266, s.2; amended 2001, c.99, s.1.

26:2-106 Reports and submissions by health care providers; rules and regulations

(a) The Commissioner of Health and Senior Services, in consultation with the Public Health Council, shall require the reporting of cases of cancer and other specified tumorous and precancerous diseases, and the submission of such specified additional information on reported cases or control populations as he deems necessary and appropriate for the recognition, prevention, cure or control of such diseases.

(b) Pursuant to subsection a. of this section, the Commissioner of Health and Senior Services is hereby authorized to adopt and promulgate, in the manner prescribed by the applicable provisions of the Administrative Procedure Act (P.L.1968,C.410;C.52:14B-1 et seq.), rules and regulations specifying the health care providers, individuals, and other organizations obliged to make the report and submissions required by subsection a. of this section, the related information to be included in such reports, and the methods for such reporting.

(c) All abstracting work performed by a health care facility in accordance with this section shall be performed by a certified tumor registrar.

(d) 1. The Department of Health and Senior Services shall contract out its registry services to health care facilities which lack adequate internal capabilities to report cases on a timely basis, as provided in the regulations adopted pursuant to this section. Such health care facilities shall reimburse the department for services rendered.

2. If a health care facility fails to correct deficiencies in its reporting that are discovered on audit by the Department of Health and Senior Services within 30 days, the department will conduct the appropriate registrar activities and charge the facility for all costs related to its services.

(e) Health insurers and other third party health care payers providing health benefits plans to residents of the State shall report to the Department of Health and Senior Services cases of cancer of State residents based upon selection criteria and in a format specified by the department.

(f) 1. A health care facility, health care provider or health insurer that fails to comply with the provisions of this section shall be liable to a penalty of up to $500 per unreported cancer case.

2. A health care facility that fails to report cases of cancer electronically, as required by regulation, within six months of the confirmed diagnosis shall be liable to a penalty not to exceed $1,000 per business day.

3. A penalty sued for under the provisions of this subsection shall be recovered by and in the name of the Department of Health and Senior Services and shall be dedicated to the cancer registry.

(g) All information reported to the Department of Health and Senior Services for inclusion in the cancer registry pursuant to this section shall be verified for accuracy by the department within six months of receiving the information and shall be incorporated in the registry. Aggregate or summary information, to include gender distribution, age groupings of cases, and cancer types, shall be made available to the public no later than six months after verification by the department. The department shall not make public any information reported to the department which discloses the identity of any person to whom the information relates.

L.1997, c.266, s.3; amended 1996, c.74, s.1; 2001, c.99, s.2

26:2-107 Confidentiality of reports

The reports made pursuant to this act are to be used only by the State Department of Health and Senior Services and such other agencies as may be designated by the Commissioner of Health and Senior Services and shall not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate; and to that end, such reports shall not be included under materials available to public inspection pursuant to P.L.1963,c73 (C.47:1A-1 et seq.).

L.1977, c.266, s.4; amended 2001, c.99, s.3

7/2005

26:2-108 Non-liability for divulging confidential information

No individual or organization providing information to the Department of Health and Senior Services in accordance with this act shall be deemed to be, or be held liable for, divulging confidential information.

26:2-109 Inapplicability of act to compel individuals to submit to medical or health department examination or supervision

Nothing in this act shall be construed to compel any individual to submit to medical or health department examination or supervision.

CHAPTER 57A

CANCER REGISTRY

Authority

N.J.S.A. 26:2-104 et. seq.

Source and Effective Date

R.1995 d.241, effective April 12, 2000,
See: 27 N.J.R. 629(a), 27 N.J.R. 1988(a),

Executive Order No. 66(1978) Expiration Date
Chapter 57A, Cancer Registry, expires on October 9, 2005

Chapter Historical Note

Chapter 57 A, Cancer Registry, became effective June 16, 1986, as R.1986 d2.77, as Subchapter 6 of N.J.A.C. 8:57. See: 17 N.J.R. 2836(b), 18 N.J.R. 1283(a). The text was recodified with amendments to N.J.A.C. 8:57A by R.1990 d.242 effective May 21, 1990. See: 21 N.J.R. 3909(a), 22 N.J.R. 1596(a).

Pursuant to Executive Order No. 66(1978), Chapter 57A was readopted as R.1995 d.241. See: Source and Effective Date. See, also, section annotations.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. CANCER REGISTRY

8:57A-1.1 Reporting of cancer; general requirements

(a) Cases of cancer and other specified tumorous and precancerous diseases shall be reported to the New Jersey Department of Health and Senior Services. The reportable diseases and conditions shall be specified in a listing promulgated by the Commissioner of the New Jersey Department of Health and Senior Services, at
N.J.A.C. 8:57A-1.8.

(b) All case reports shall be submitted within six months of the date of diagnosis or within three months of the date of discharge from the reporting facility, whichever is sooner.

(c) Follow-up reports shall be submitted on each cancer case at least annually to confirm the patient's vital status. These follow-up reports shall be required until the patient's death.

Amended by R.1990 d.242, effective May 21, 1990.
See: 21 N.J.R. 3909(a), 22 N.J.R. 1596(a).
Third party payers permitted to report cases to the Registry; machine readable submissions permitted.
Amended by R.1995 d.241, effective May 15, 1995.
See: 27 N.J.R. 629(a), 27 N.J.R. 1988(a).
Amended by R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903(b).
Rewrote the section.

8:57A-1.2 Health care facility reporting

(a) The administrative officer of every health care facility shall report to the New Jersey Department of Health and Senior Services every case of cancer or other specified tumors and precancerous disease when it is initially diagnosed or when the patient is first admitted or treated for any reason in that facility. A report shall also be submitted for each subsequent primary cancer diagnosed in that individual.

1. Health care facility means a facility as defined at N.J.S.A. 26:2H-1 et. seq. and amendments thereto.

(b) All abstracting work performed by a health care facility which diagnoses or treats 100 or more cancer cases per year shall be performed by a certified tumor registrar who is certified by the National Cancer Registrars Association's Council on Certification, 1340 Braddock Avenue, Alexandria, VA 22314; http:llwww.ctrexam.org; telephone: (703) 299-6640; telefacsimile: (703) 299-6620; e-mail: ctrexam@ncra-usa.org. The certified tumor registrar shall be either employed by the health care facility or employed by an abstract-coding service under contract by the health care facility.

1. The health care facility shall have until August 3, 2000 to comply with the provisions of (b) above.

(c) The information to be reported shall:

1. Be submitted electronically in a standard format which is specified by the New Jersey Department of Health and Senior Services; and

2. Include patient identifying information, medical history, cancer treatment, and an annual report to confirm the patient=s vital status until the patient=s death.

(d) Health care facilities which lack adequate internal capabilities to report cases in accordance with the requirements of (b) and (c) above shall contract with the New Jersey Department of Health and Senior Services to provide abstracting services.

(e) The New Jersey Department of Health and Senior Services shall charge a fee to health care facilities for the provision of services set forth at (d) above. The fee shall be based upon the fair market value of services.

(f) A health care facility which fails to comply with the provisions of this subchapter shall be liable for a penalty of up to $500.00 per unreported case of cancer or other specified tumorous and precancerous disease.

(g) A health care facility which fails to report cases of cancer or other specified tumorous and precancerous diseases electronically shall be liable to a penalty not to exceed $1,000 per business day.

Recodified from N.J.A.C. 8:57A-1.1(b) and amended by
R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903 (b).
Rewrote the section. Former N.J.A.C. 8:57A-1.2, Reportable list, was recodified to N.J.A.C. 8:57A-1.8.

8:57A-1.3 Physician, dentist, and other health care provider reporting

(a) Every physician, dentist, or other health care provider who diagnoses or provides treatment for cancer patients shall report to the New Jersey Department of Health and Senior Services an initial diagnosis of each case of cancer or other specified tumorous and precancerous disease not referred to or previously diagnosed in a health care facility in the State of New Jersey. A report shall also be submitted for each subsequent primary cancer diagnosed in that individual.

(b) The information to be reported shall:

1. Be submitted on forms specified by the New Jersey Department of Health and Senior Services; and

2. Include patient identifying information, medical history, and cancer treatment.

(c) The physician, dentist, or other health care provider may submit the reports electronically in a standard format which is specified by the New Jersey Department of Health and Senior Services.

(d) A physician, dentist or other health care provider who fails to comply with the provisions of this subchapter shall be liable for a penalty of up to $500.00 per unreported case of cancer or other specified tumorous and precancerous disease.

Recodified from N.J.A.C. 8:57A-1.1 (c) and amended by
R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759 (a), 30 N.J.R. 2903(b).
Rewrote the section.

8:57A-1.4 Clinical laboratory reporting

(a) The director of every independent clinical laboratory shall report to the New Jersey Department of Health and Senior Services the results of examinations of tissue specimens and/or hematology examinations which are positive for the existence of cancer or other specified tumorous and precancerous disease not previously reported from that laboratory.

(b) The information to be reported shall:

1. Be submitted on forms specified by the New Jersey Department of Health and Senior Services; and

2. Include all available patient identifying information and the name, address, and/or telephone number of the referring physician.

(c) The director of the independent clinical laboratory may submit the reports electronically in a standard format which is specified by the New Jersey Department of Health and Senior Services.

(d) An independent clinical laboratory which fails to comply with the provisions of this subchapter shall be liable for a penalty of up to $500.00 per unreported case of cancer or other specified tumorous and precancerous disease.

Recodified from N.J.A.C. 8:57A-1.1(d) and amended by
R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903 (b).
Rewrote the section.

8:57A-1.5 Health care insurer reporting

(a) Health care insurers and other third party health care payers providing benefit plans to residents of the State may report to the New Jersey Department of Health and Senior Services cases of cancer or other specified tumorous and precancerous diseases based upon selection criteria specified by the Cancer Registry.

(b) If reported, the information shall:

1. Be submitted on forms specified by the New Jersey Department of Health and Senior Services; and

2. Include patient identifying information, medical history, cancer treatment, and an annual report to confirm the patient's vital status until the patient's death.

(c) Health care insurers and other third party health care payers providing benefit plans to residents of the State may submit the reports electronically in a standard format which is specified by the New Jersey Department of Health and Senior Services.

Recodified from N.J.A.C. 8:57A-1.1(e) and amended by
R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903(b).
Rewrote the section.

8:57A-1.6 Supplemental information

Information necessary to clarify medical or demographic data shall be supplied upon request of the New Jersey

Department of Health and Senior Services. This supplemental information shall include, but not be limited to: copies of pathology and/or hematology reports, operative reports, treatment information, history and physical sections of the medical records, and discharge summaries.

Recodified from N.J.A.C. 8:57A-1.1(f) and amended by
R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J. R. 2903(b).
Rewrote the section.

8:57A1-7. Access to information and records

(a) Every health care facility, independent clinical laboratory, physician, dentist, or other health care provider who diagnoses or provides treatment for cancer patients and health care insurers and other third party health care payers providing benefit plans to residents of the State shall allow representatives of the New Jersey Department of Health and Senior Services to obtain information from all medical, pathological, and other pertinent records and logs related to cancer cases, as necessary for fulfilling the functions of the cancer registry program.

(b) Every health care facility, independent clinical laboratory, physician, dentist, or other health care provider who diagnoses or provides treatment for cancer patients and health care insurers and other third party health care payers providing benefit plans to residents of the State shall permit representatives of the New Jersey Department of Health and Senior Services access to information or provide necessary information on specified cancer patients and other patients specified by characteristics for research studies related to cancer etiology, prevention, and control which are conducted by the New Jersey Department of Health and Senior Services. These studies, shall have been approved by the Commissioner of the New Jersey Department of Health and Senior Services after appropriate review to assure protection of human subjects. This access or provision of information shall include patients who came under the care of the health care facility, physician, dentist, or other health care provider prior to November 18, 1977.

(c) The reports made pursuant to this subchapter shall be used only by the New Jersey Department of Health and Senior Services and such other agencies as may be designated by the Commissioner of the New Jersey Department of Health and Senior Services. These reports shall not be otherwise divulged or made public. Such reports shall not be subject to public inspection and copying pursuant to the Right-to-Know Act, N.J.S.A. 47:1A-1 et seq.

(d) No individual or organization providing information to the New Jersey Department of Health and Senior Services in accordance with this subchapter shall be deemed to be, or held liable for, divulging confidential information.

(e) Any individual or organization which reveals or discloses any information or data in violation of (c) above shall be the subject of penalties as permitted by law. All violations shall be reported to the appropriate professional licensing authorities and public financing programs.

(f) Failures to permit access to information and records to representatives of the New Jersey Department of Health and Senior Services shall be cause for the imposition of penalties as permitted by law.

Recodified from N.J.A.C. 8:57A-1.1(i) and (j) and amended by R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903(b).
Rewrote the section.

8:57A-1.8 List of reportable diseases and conditions

(a) If a diagnosis includes any of the following words, the case shall be reported to the New Jersey Department of Health and Senior Services in accordance with the provisions of this subchapter:

Cancer;
Carcinoma;
Leukemia;
Malignant; and/or
Sarcoma.

(b) Any case having a diagnosis listed at (g) below and which contains any of the following terms in the final diagnosis shall be reported to the New Jersey Department of Health and Senior Services in accordance with the provisions of this subchapter:

Compatible with;
Consistent with;
Most likely;
Probable;
Suspect; and/or
Suspicious.

(c) Basal cell carcinomas of the skin shall not be reported to the New Jersey Department of Health and Senior Services except when they are diagnosed in the labia, clitoris, vulva, prepuce, penis, or scrotum.

(d) Carcinoma *in situ* of the cervix shall not be reported to the New Jersey Department of Health and Senior Services.

(e) Insofar as soft tissue tumors can arise in almost any body site, the primary site of the soft tissue tumor shall also be examined for any questionable neoplasm.

(f) If any uncertainty regarding the reporting of a particular case exists, the New Jersey Department of Health and Senior Services shall be contacted for guidance.

(g) Every New Jersey health care facility, physician, dentist, other health care provider, or independent clinical laboratory shall report the following conditions to the New Jersey Department of Health and Senior Services in accordance with the provisions of this subchapter:

ADRENAL
Adrenal cortical carcinoma
Ganglioneuroblastoma
Neuroblastoma
Neuroendocrine carcinoma
Neuroepithelioma
Paraganglioma (+)
Pheochromocytoma, malignant only
Sympathicoblastoma

ANUS (see G-I tract)

APPENDIX (see G-I tract)

BILE DUCTS (see gall bladder and bile ducts)

BLOOD (see Hematopoietic/Lymphoid)

BLOOD VESSELS (see soft tissues)

BONE AND JOINTS

Adamantinoma
Ameloblastoma, malignant
Angioblastoma (+)
Angiosarcoma
Chondrosarcoma
Chordoma
Ewing's Sarcoma
Fibrosarcoma (medullary, periosteal, central, endosteal)
Giant cell tumor of bone (+)
Giant cell tumor, malignant
Hemangioendothelioma, malignant
Mesenchymal chondrosarcoma
Myeloma
Osteoclastoma (+)
Osteogenic Sarcoma
Osteosarcoma
Periosteal osteoma
Plasmacytoma

BONE MARROW (see Hematopoietic/Lymphoid)

BRAIN, SPINAL CORD, CRANIAL NERVES MENINGES, Central Nervous System

Acoustic neuroma (O)
Angiolipoma (O)
Angiomatous meningioma (O)
Astroblastoma
Astrocytoma (any type)
Atypical choroid plexus papilloma (+)
Atypical lipoma (+)
Atypical meningioma (+)
Capillary hemangioma (O)
Cavernous hemangioma (O)
Central neurocytoma (+)
Chordoid glioma (+)
Chordoid plexus papilloma, malignant
Choroid plexus papilloma (O)
Clear cell meningioma (+)
Dermoid cyst (O)
Desmoplastic infantile astrocytoma (+)
Diffuse melanocytosis (O)
Dysembryoplastic neuroepithelial tumor (O)
Dyplastic gangliocytoma of cerebellum (O) (Lhermitte-Ducios)
Ependymoblastoma
Ependymoma
Fibrolipoma (O)
Fibroma (O)
Fibrous meningioma (O)
Gangliocytoma (O)
Ganglioglioma (+)
Ganglioneuroblastoma
Ganglioneuroma (O)
Germinoma
Glioblastoma multiforme
Gliofibroma (+)
Glioma, all types
Gliomatosis cerebri (+)
Hemangioblastoma (+)
Hemangioendothelioma, benign (O)
Hemangioendothelioma (+)
Hemangioma (O)
Hemangiopericytoma, benign (O)
Hemangiopericytoma (+)
Hemangiopericytoma, malignant
Leiomyoma (O)
Leiomyomatosis (+)
Lipoma (O)
Medulloblastoma
Medulloepithelioma (O)
Melanotic neurofibroma (O)
Meningeal melanocytoma (+)
Meningioma, malignant
Meningioma (O)
Meningiomatosis (+)
Meningiotheliomatous meningioma (O)
Meningiothelial meningioma (O)
Myxopapillary ependymoma (+)
Neoplasm, benign (O)
Neoplasm, uncertain whether benign or malignant (+)
Neurilemoma (O)
Neurinomatosis (+)
Neuroblastoma
Neurofibroma (O)
Neurofibromatosis (+)
Neuroma (O)
Neurothekeoma (O)
Oligodendrocytoma or Oligodendroblastoma
Oligodendroglioma
Papillary meningioma
Paraganglioma (+)
Perineurioma (O)
Pineal teratoma, malignant
Pinealoma
Pineoblastoma
Pineocytoma
Plexiform neurofibroma (O)
Polarespongioblastoma
Psammomatous meningioma (O)
Rhabdomyoma (O)
Schwannoma (any)
Smooth muscle tumor (+)
Soft tissue tumor, benign (O)
Solitary fibrous tumor (O)
Spongioblastoma
Subependymal astrocytoma
Subependymal giant cell astroctyoma (+)
Subependymoma (+)
Teratoma, benign (O)
Teratoma (+)
Transitional meningioma (O)
Tumor cells, benign (O)
Tumor cells, malignant
Venous hemangioma (O)

BREAST

Adenocarcinoma
Apocrine carcinoma
Colloid carcinoma
Comedocarcinoma
Cribriform carcinoma
Cystosarcoma phyllodes, malignant only
Ductal carcinoma, in situ
Fibroadenoma, malignant only
Glycogen rich carcinoma

Infiltrating carcinoma of the breast such as:
- Carcinoma, NOS
- Duct adenocarcinoma
- Duct and lobular
- Duct carcinoma
- Duct and Paget's disease
- Ductular
- Lobular
- Lipid-rich carcinoma
- Lobular carcinoma, in situ
- Lobular and intraductal, in situ
- Lobular neoplasia
- Medullary carcinoma
- Papillary carcinoma, in situ
- Paget's disease
- Phyllodes tumor, malignant
- Stromal sarcoma of breast
- Tubular carcinoma

BRONCHUS (see lung)

CERVIX (see uterus)

COLON (see G-I tract)

EAR (see skin, soft tissue)

ENDOMETRIUM (see uterus)

ESOPHAGUS (see G-I tract)

EYE
- Epidermoid carcinoma
- Melanoma, malignant
- Retinoblastoma
- Squamous cell carcinoma
- Squamous cell epithelioma
- (Tumors of the orbit:
- See soft tissues and Hematopoietic/Lymphoid)

EXTRA-ADRENAL PARAGANGLIA (see adrenal)

FALLOPIAN TUBE (see uterus)

GALL BLADDER AND BILE DUCTS
- Adenocarcinoma
- Carcinoma (other)

GASTRO-INTESTINAL TRACT (esophagus, stomach, intestine, appendix, colon, anus)
- Adenoacanthoma
- Adenocarcinoma
- Adenoidcystic carcinoma
- (Adeno) carcinoma in Adenomatous polyp with or without invasion of stalk
- Adenosarcoma
- AIN
- Apudoma (+)
- Argentaffinoma (+)
- Bowen's disease of anus
- Carcinoid (except benign - e.g. appendix)
- Carcinosarcoma
- Cloacogenic carcinoma
- Epidermoid carcinoma
- Gastrinoma (+)
- Immunoproliferative disease, small intestinal
- Kaposi's Sarcoma
- Leiomyosarcoma, malignant only
- Lenitis plastica
- Lymphoma
- Mixed tumor or esophagus, malignant only
- Neuroendocrine carcinoma
- Paget's disease of anus
- Polypoid adenoma, malignant only
- Signet ring cell carcinoma
- Squamous cell carcinoma
- Squamous cell epithelioma
- Transitional cell carcinoma

HEMATOPOIETIC/LYMPHOID (Including blood, bone marrow, lymph nodes, spleen, and tumors of hematopoietic or lymphoid histogenesis found in other sites.)
- Acute erythremic myelosis
- Acute megakaryocytic myelosis
- Chronic myeloproliferative disease
- DiGuglielmo's syndrome
- Erythroleukemia
- Essential thrombocythemia
- Gamma heavy chain disease (Franklin's Disease)
- Histiocytic medullary reticulosis
- Histiocytosis, malignant
- Histiocytosis-X, malignant only
- Hodgkin's Disease, all such as:
  - Histiocyte predominant
  - Lymphocyte depleted
  - Lymphocyte predominant
  - Mixed cellularity
  - Nodular sclerosing
- Hypereosinophilic syndrome
- Idiopathic thrombocythemia
- Immunoproliferative Disease, NOS
- Letterer-Siwe's Disease
- Leukemia, all
- Leukemic reticuloendotheliosis
- Lymphoma, all
- Lymphosarcoma
- Lymphoreticular process, malignant
- Megakaryocytosis, malignant
- Multiple myeloma
- Mycosis fungoides
- Myelodysplastic syndrome, 5q- syndrome
- Myelofibrosis with myeloid metaplasia, malignant only
- Myeloma
- Myeloproliferative disease (+)
- Myelosclerosis
- Panmyelosis, acute
- Polycythemia Vera
- Refractory anemia
- Reticulosis, malignant
- Reticulum cell sarcoma
- Sezary's disease or syndrome
- Therapy related myelodysplastic syndrome
- Waldenstrom's macroglobulinemia or syndrome

HYPOPHARYNX (See oral cavity)

KIDNEY
- Adenocarcinoma
- Adenomyosarcoma
- Clear cell carcinoma
- Hypernephroma
- Nephroblastoma
- Renal cell carcinoma

Squamous cell carcinoma
Transitional cell carcinoma
Tubular adenoma, borderline or malignant only
Wilms's Tumor

LARYNX AND TRACHEA
Adenocarcinoma
Adenocystic carcinoma
Cylindroma
Squamous cell carcinoma

LIP (see oral cavity)

LIVER
Angiosarcoma
Bile duct carcinoma
Cholangiocarcinoma
Hepatoblastoma
Hepatocellular carcinoma
Hepatoma, malignant only

LUNG AND BRONCHUS
Adenocarcinoma
Adenoid cystic carcinoma
Apudoma (+)
Argentaffinoma (+)
Bronchial adenoma (+)
Bronchial adenoma (carcinoid type)
Cylindroma
Epidermoid carcinoma
Intravascular bronchial alveolar tumor
Large cell (anaplastic) carcinoma
Neuroendocrine carcinoma
Oat cell carcinoma
Pulmonary blastoma
Small cell (anaplastic) carcinoma
Squamous cell carcinoma
Undifferentiated carcinoma

LYMPH NODE (See Hematopoietic/Lymphoid)

MEDIASTINUM
(see Hematopoietic/Lymphoid, soft tissue, or thymus)

MENINGES (see brain)

MUSCLE (see soft tissue)

NERVE (see soft tissue)

NOSE (Nasal cavity, Para-nasal sinus and Nasopharynx)
Adenocarcinoma
Epidermoid carcinoma
Esthesioneuroblastoma
Lymphoepithelioma
Mesenchymoma, malignant
Neuroblastoma
Rhabdomyosarcoma
Sarcoma botryoides
Squamous cell carcinoma

ORAL CAVITY AND SALIVARY GLANDS
Adenocarcinoma
Adenoid cystic carcinoma
Acinic cell carcinoma
Acinic cell tumor (+)
Cylindroma
Epidermoid carcinoma
Lymphoepithelioma
Melanoma
Mixed tumor, salivary gland type, malignant only
Mucoepidermoid carcinoma
Mucoepidermoid tumor (+)
Pleomorphic adenoma, malignant only
Squamous cell carcinoma
Transitional cell carcinoma
Undifferentiated carcinoma
Verrucous carcinoma

OROPHARYNX (see oral cavity)

OVARY
Adenocarcinoma, NOS
Arrhenoblastoma, malignant
Brenner tumor, malignant only
Choriocarcinoma
Clear cell carcinoma
Dysgerminoma
Embryonal carcinoma
Endodermal sinus tumor
Endometrioid carcinoma
Granulosa cell tumor (+)
Granulosa cell carcinoma
Granulosa cell tumor, malignant
Granulosa-theca cell tumor (+)
Gonadoblastoma (+)
Gynandroblastoma (+)
Leydig cell tumor, malignant
Mesonephroid carcinoma
Mucinous cystadenoma, borderline malignancy (pseudomucinous cystadenoma, borderline malignancy) (+)
Mucinous cystadenocarcinoma
Mucinous cystic tumor of borderline malignancy (+)
Mucinous papillary cystadenoma of borderline malignancy (+)
Mucinous papillary cystadenoma with low malignant potential (+)
Papillary cystadenoma, borderline malignancy (+)
Papillary mucinous cystadenoma, borderline malignancy (+)
Papillary mucinous tumor of low malignant potential (+)
Papillary serous cystadenoma, borderline malignancy (+) (papillary serous tumor of low malignant potential)
Papillary serous cystadenocarcinoma
Pseudomucinous cystadenocarcinoma
Seminoma
Serous cystadenoma, borderline malignancy (+)
Serous papillary cystadenocarcinoma
Serous papillary cystadenoma of borderline malignancy (+)
Serous papillary cystadenoma with low malignant potential (+)
Serous papillary cystic tumor borderline malignancy (+)
Sertoli-leydig cell carcinoma
Teratoma, malignant
Theca-granulosa cell tumor (+)
Yolk-sac tumor

PANCREAS
Adenocarcinoma
Cystadenocarcinoma
Gastrinoma (+)
Glucagonoma, malignant only

Islet cell adenoma (+)
Islet cell carcinoma
Pancreatoblastoma
Papillary cystic tumor (+)
Squamous cell carcinoma

PARAGANGLIA
Non-chromaffin paraganglioma (+)
(see also adrenal gland)

PARATHYROID
Carcinoma, all

PARANASAL SINUSES (see nose)

PENIS
Basal cell carcinoma of Penis and Prepuce (skin of)
Bowen's disease
Erythroplasia of Queyrat
Squamous cell carcinoma
Verrucous carcinoma

PERICARDIUM (see pleura)

PERITONEUM (see pleura)

PHARYNX (see oral cavity)

PINEAL
Dermoid cyst (O)
Epithelial tumor, benign (O)
Gangliocytoma (O)
Ganglioglioma (+)
Neoplasm, benign (O)
Pinealoma (+)
Pineoblastoma
Pineocytoma (+)
Teratoma, benign (O)
Teratoma (+)

PITUITARY and CRANIOPHARYNGEAL DUCT
Acidophil adenoma (O)
Adamanthinomatous craniopharyngioma (+)
Adenoma (O)
Basophil adenoma (O)
Chromophobe adenoma (O)
Clear cell adenoma (O)
Clear cell tumor (O)
Craniopharyngioma (any type) (+)
Craniopharyngioma, malignant
Epithelial tumor, benign (O)
Granular cell tumor (O)
Lipoma (O)
Mixed acidophil-basophil adenoma (O)
Mixed cell adenoma (O)
Monomorphic adenoma (O)
Neoplasm, uncertain (+)
Neoplasm, benign (O)
Oxyphilic adenoma (O)
Papillary adenoma (O)
Papillary craniopharyngioma (+)
Pituitary adenoma (O)
Prolactinoma (O)
Rathke Pouch tumor (+)
Soft tissue tumor, benign (O)
Teratoma, benign (O)
Teratoma (+)
Tumor cells, benign or uncertain

PLACENTA
Choriocarcinoma
Chorioepithelioma
Hydatiform mole, malignant (+)
Invasive mole (+)

PLEURA, PERITONEUM, PERICARDIUM
Fibrosarcoma
Mesothelioma
Sarcoma

PROSTATE AND SEMINAL VESICLE
Adenocarcinoma
Adenoid cystic carcinoma
Alveolar rhabdomyosarcoma
Carcinosarcoma
Endometrioid carcinoma
Rhabdomyosarcoma

RECTUM (see G-I Tract)

SALIVARY GLANDS (see oral cavity)

SKIN
Amelanotic melanoma
Basal cell carcinoma of labia, clitoris, vulva, prepuce, penis and scrotum
Bowen's disease of anus and penis
Hutchinson's melanotic freckle
Lentigo maligna
Melanocarcinoma
Melanoma
Melanosarcoma
Merkel cell tumor
Mycosis Fungoides
Pilomatrix carcinoma
Squamous cell carcinoma with regional or distant spread only
Superficial spreading melanoma
Sweat gland carcinoma

SOFT TISSUE (Including retroperitoneum, peripheral nerve)
Alveolar rhabdomyosarcoma
Alveolar soft parts sarcoma
Angiofibrosarcoma
Angiosarcoma
Angiomyxoma (+)
Chondrosarcoma
Clear cell sarcoma of tendons
Dermatofibrosarcoma protuberans
Embryonal rhabdomyosarcoma
Fibromyxosarcoma
Fibrosarcoma
Fibrous histiocytoma, malignant
Granular cell tumor, malignant
Hemangioendothelial sarcoma
Hemangioendothelioma, malignant only
Hemangiopericytoma, malignant only
Juvenile rhabdomyosarcoma
Kaposi's sarcoma
Leiomyosarcoma
Liposarcoma
Lymphangioendothelioma, malignant
Lymphangiosarcoma
Mesenchymoma, malignant
Metastasizing leiomyoma (+)
Myosarcoma

Myxosarcoma
Neuroblastoma
Neurogenic sarcoma
Neurilemmoma, malignant
Neurilemmosarcoma
Osteosarcoma
Paraganglioma, malignant
Pigmented dermatofibrosarcoma protuberans Bednar tumor
Reticulum cell sarcoma
Rhabdomyoma, malignant
Rhabdomyosarcoma
Sarcoma botryoides
Schwannoma, malignant
Schwannoma, malignant with rhabdomyoblastomatous differentiation
Synovial sarcoma
Xanthofibroma, malignant

SPINAL CORD (see brain)

SPLEEN (see Hematopoietic/Lymphoid)

STOMACH (see G-I Tract)

TESTIS
Carcinoid tumor (+)
Choriocarcinoma
Chorioepithelioma
Embryoma
Embroyonal carcinoma
Emroyonal teratomaa
Endodermal sinus tumor
Germ cell carcinoma
Gonadal stromal tumor, malignant only
Gonadoblastoma (+)
Interstitial cell carcinoma
Leydig cell carcinoma
Mesonephric adenocarcinoma (infantile, juvenile embryonal carcinoma)
Polyembryoma
Seminoma
Sertoli cell carcinoma
Spermatoblastoma
Spermatocyctic seminoma
Spermatocytoma
Teratoblastoma
Teratocarcinoma
Teratoma (+)
Vitelline tumor
Yolk sac tumor

THYMUS
Epithelioid thymoma, malignant only
Lymphocytic thymoma, malignant only
Seminoma
Spindle cell thymoma, malignant only
Thymic carcinoid
Thymoma, malignant

THYROID
Adenocarcinoma
Anaplastic carcinoma
Follicular carcinoma
Giant cell carcinoma
Hurthle cell adenoma, malignant only
Hurthle cell tumor, malignant only
Medulllary carcinoma
Occult sclerosing carcinoma
Papillary carcinoma = papillary adenocarcinoma
Undifferentiated carcinoma

TRACHEA (see Larynx)

URINARY BLADDER, URETER, URETHRA
Adenocarcinoma
Adenosarcoma
Carcinosarcoma
Chemodectoma, malignant only
Mullerian mixed tumors
Papillary transitional cell carcinoma
Paraganglioma (+)
Pheochromocytoma, malignant only
Rhabdomyosarcoma
Squamous cell carcinoma
Transitional cell carcinoma

UTERUS, UTERINE TUBES, CERVIX
Adenoacanthoma
Adenocarcinoma
Adenosarcoma
Adenosquamous carcinoma
Endolymphatic stromal myosis
Endometrial stromal sarcoma
Endometrioid carcinoma
Leiomyosarcoma
Mesonephric carcinoma
Mixed mesodermal tumor
Squamous cell carcinoma

VULVA AND VAGINA
Basal cell carcinoma of vulva, clitoris, and labia
Clear cell carcinoma
Mesonephroid carcinoma
Paget's disease
Squamous cell carcinoma
Vaginal intraepithelial neoplasia (VAIN III)
Vulvar intraepithelial neoplasia (VIN III)

NOTE: The following superscript indicates the nature of the other than overtly malignant reportable tumors listed:

(+) Borderline, reportable
(O) Benign, reportable

Amended by R.1990 d.242, effective May 21, 1990.
See: 21 N.J.R. 3909(a), 22 N.J.R. 1596(a).
Fourteen conditions added to list.
Repeal and New Rule, R.1995 d.241, effective May 15, 1995.
See: 27 N.J.R. 629(a), 27 N.J.R. 1998(a).
Recodified from N.J.A.C. 8:57A-1.2 and amended by R.1998 d.393, effective August 3. 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903(b).
Rewrote the section.

8:57A-1.9 Audit, notice of violations, and enforcement actions

(a) A health care facility, physician's, dentist's, other health care provider's office, or independent clinical laboratory shall be subject to audit at the discretion of the Commissioner by authorized representatives of the New Jersey Department of Health and Senior Services.

(b) The New Jersey Department of Health and Senior Services shall evaluate completeness and timeliness of reporting as specified by this chapter. Records which shall be reviewed shall include, but not be limited to: medical records, diagnostic indices; such as, radiation, laboratory, cytology, and/or pathology reports, and discharge records.

(c) The audit shall be conducted during normal operating hours.

(d) A deficiency may be cited upon a determination that the health care facility, physician's, dentist's, other health care provider's office, or independent clinical laboratory does not comply with the reporting requirements to this chapter.

(e) At the conclusion of the audit or within 10 business days thereafter, the New Jersey Department of Health and Senior Services shall provide the health care facility, physician's, dentist's, other health care provider's office, or independent clinical laboratory with a written summary of any factual findings used as a basis to determine that reporting has not been complete or timely. This notice shall set forth the proposed assessment of civil monetary penalties, setting forth the specific reasons for the action. Such notice shall be served on a facility, physician, dentist, other health care provider, or independent clinical laboratory or its, his or her registered agent in person or by certified mail.

(f) A health care facility, physician, dentist, other health care provider, or independent clinical laboratory shall have 30 business days in which to correct all deficiencies in its reporting that were discovered during the audit.

1. If a health care facility, physician, dentist, other health care provider, or independent clinical laboratory fails to correct deficiencies in its reporting that were discovered during the audit within 30 days, the New Jersey Department of Health and Senior Services will act as registrar and shall charge the facility, physician, dentist, other health care provider, or independent clinical laboratory for all costs related to these services, including, but not limited to, the retrieval of case information and the cost of the audit. This fee shall be based upon the fair market value of such services.

i. All checks for fees for the Department's audit services shall be made payable to Treasurer, State of New Jersey and forwarded to:

Cancer Epidemiology Services
New Jersey State Cancer Registry
New Jersey Department of Health and Senior Services
PO Box 369
Trenton, New Jersey 08625-0369

New Rule, R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903 (b).

8:57A-1.10 Civil monetary penalties

(a) Pursuant to N.J.S.A. 26:2-106f(3) and notwithstanding the provisions of N.J.A.C. 8:57A-1.9(f)1 above, the Commissioner may assess a penalty for violation of reporting requirements in accordance with the following standards:

1. For failure of a health care facility physician, dentist, other health care provider, or independent clinical laboratory to report pursuant to the provisions of this chapter, up to $500.00 per unreported case of cancer or other specified tumorous and precancerous disease; and/or

2. For failure of a health care facility to report electronically, up to $1,000 per business day.

(b) The Department may decrease the penalties in (a) above based upon compliance history, the number and frequency of the deficiencies, the measures taken to mitigate or prevent future deficiencies, the deterrent effect of the penalty, and/or other specific circumstances of the facility or violation.
New Rule, R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a). 30 N.J.R. 2903(b).

8:57A-1.11 Effective date of enforcement action

The assessment of civil monetary penalties shall become effective 30 days after the date of mailing or the date personally served, unless the health care facility, physician, dentist, other health care provider, or independent clinical laboratory files with the Department a written answer to the charges and gives written notice to the Department of its desire for a hearing. In this case, the assessment shall be held in abeyance until the administrative hearing has been conducted and a final decision is rendered by the Commissioner. Hearings shall be conducted in accordance with N.J.A.C. 8:57A-1.13.

New Rule, R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903(b).

8:57A-1.12 Failure to pay a penalty; remedies

(a) Upon receipt of a Notice of Proposed Assessment of a Penalty, a health care facility, physician, dentist, other health care provider, or independent clinical laboratory has 30 days in which to notify the Department of its request for a hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

(b) The penalty becomes due and owing upon the 30th day from receipt of the Notice of Proposed Assessment of Penalties if a notice requesting a hearing has not been received by the Department. If a hearing has been requested, the penalty is due 45 days after the issuance of a Final Agency Decision by the Commissioner, if the Department's assessment has not been withdrawn, rescinded, or reversed, and an appeal has not been timely filed with the Appellate Division pursuant to Rule 2:2-3 of the New Jersey Court Rules.

(c) Failure to pay a penalty within 30 days of the date it is due and owing pursuant to (b) above may result in the institution of a summary civil proceeding by the State pursuant to the Penalty Enforcement Law,
N.J.S.A. 2A:58-1 et seq.

New Rule, R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903(b).

8:57A-1.13 Hearings

(a) Upon request, a hearing shall be afforded to a health care facility, physician, dentist, other health care

provider, or independent clinical laboratory pursuant to N.J.A.C. 8:57A-1.9.

(b) A health care facility, physician, dentist, other health care provider, independent clinical laboratory shall notify the Department, in writing, of its request for a hearing within 30 days of receipt of a Notice of Proposed Assessment of Penalties.

(c) The Department shall transmit the hearing request to the Office of Administrative Law.

(d) Hearings shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et. seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1.1.

New Rule, R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903(b).

8:57A-1.14 Settlement of enforcement actions

(a) A health care facility, physician, dentist, other health care provider, or independent clinical laboratory may request that the matter be settled in lieu of conducting an administrative hearing concerning an enforcement action.

(b) If the Department and the health care facility, physician, dentist, other health care provider, or independent clinical laboratory agree on the terms of a settlement, a written agreement specifying these terms shall be executed.

(c) The Department may agree to accept payment of penalties over a schedule not exceeding 18 months where a health care facility, physician, dentist, other health care provider, or independent clinical laboratory demonstrates financial hardship.

(d) All funds received in payment of penalties shall be recovered by and in the name of the Department and shall be dedicated to the New Jersey State Cancer Registry.

New Rule, R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903(b).

Appendix F

Common Acceptable Medical Abbreviations

COMMON ACCEPTABLE ABBREVIATIONS

Abdomen	ABD
Abdominal Perineal	AP
Above Knee (Amputation)	AK(A)
Acid Phosphatase	ACID PHOS
Acquired Immunodeficiency Syndrome	AIDS
Acute Granulocytic Leukemia	AGL
Acute Lymphocytic Leukemia	ALL
Acute Myelogenous Leukemia	AML
Adenocarcinoma	ADENOCA
Adjacent	ADJ
Admission; Admit	ADM
Against Medical Advice	AMA
Aids Related Complex	ARC
Alcohol	ETOH
Alkaline-Phosphatase	ALK PHOS
Alpha-fetoprotein	AFP
Also Known As	AKA
Ambulatory	AMB
Anaplastic	ANAP
Angiography	ANGIO
Anterior	ANT
Anteroposterior	AP
Appendix	APP
Approximately	APPROX
Arteriovenous	AV
Aspiration	ASP
Auscultation & Percussion	A&P
Autopsy	AUT
Axilla(ry)	AX
Bacillus Calmette-Guerin	BCG
Barium	BA
Barium Enema	BE
Bartholin's, Urethral, & Skene's Glands	BUS
Below Knee (Amputation)	BK(A)
Benign Prostatic Hypertrophy/Hyperplasia	BPH
Bilateral	BIL
Bilateral Salpingo-oophorectomy	BSO
Bile Duct	BD
Biological Response Modifier	BRM
Biopsy	BX
Blood Urea Nitrogen	BUN
Bone Marrow	BM
Bone Scan	BSC
Bowel Movement	BM
Bowel Sounds	BS
Breath Sounds	BS, BRS
Bright Red Blood (per Rectum)	BRB(PR)
Calcium	CA
Carcinoembryonic Antigen	CEA
Carcinoma	CA
Carcinoma In Situ	CIS
CAT Scan	CT, CT SC
Centimeter	cm
Central Nervous System	CNS
Cerebrospinal Fluid	CSF
Cervical Intraepithelial Neoplasia	CIN
Cervical Vertebra	C1-C7
Cervix	CX
Cesium	CS
Chemotherapy	CHEMO
Chest X-ray	CXR
Chief Complaint	CC
Chronic Granulocytic Leukemia	CGL
Chronic Lymphocytic Leukemia	CLL
Chronic Myeloid Leukemia	CML
Cigarettes	CIG
Clear	CLR
Colon	
Ascending	A-COLON
Descending	D-COLON
Sigmoid	S-COLON
Transverse	T-COLON
Common Bile Duct	CBD
Complaining of	C/O
Complete Blood Count	CBC
Computerized Axial Tomography	

Scan	CT, CAT SCAN
Consistent with	C/W
Cubic Centimeter	CC
Cystoscopy	CYSTO
Cytology	CYTO
Cytomegalovirus	CMV
Date of Birth	DOB
Dead on Arrival	DOA
Decreased	DECR (or <)
Dermatology	DERM
Diagnosis	DX
Diameter	DIAM
Differentiated	DIFF
Dilatation and Curettage	D&C
Discharge	DIS, DISCH, DS
Discontinued	DC
Disease	DZ, DIS
Doctor	DR, MD
Ears, Nose, and Throat	ENT
Electroencephalogram	EEG
Electromyogram	EMG
Emergency Room	ER
Endoscopic Retrograde Cholangiopancreatography	ERCP
Enlarged	ENL
Esophagogastroduodenoscopy	EGD
Estrogen Receptor (Assay)	ER(A)
Evaluation	EVAL
Examination	EXAM
Examination under Anesthesia	EUA
Excision	EXC
Exploratory Laparotomy	EXP LAP
Extend	EXT
Extended Care Facility	ECF
Extension	EXT
External	EXT
Extremity	EXT
Eyes, Ears, Nose, and Throat	EENT
Family (Medical) History	F(M)H
Fever Unknown Origin	FUO
Fingerbreadth	FB
Floor of Mouth	FOM
Follow-up	FU
Continue	CONT
Costal Margin	CM
Fracture	FX
Frozen Section	FS
Gallbladder	GB
Gastroenterostomy	GE
Gastroesophageal	GE
Gastrointestinal	GI
Genitourinary	GU
Grade	GR
Gram	GM
Gynecology	GYN
Head, Eyes, Ears, Nose, Throat	HEENT
Hematocrit	HCT
Hemoglobin	HGB
History	HX
History and Physical	H&P
History of	HO
History of Present Illness	HPI
Hormone	HORM
Hospital	HOSP
Hour, Hours	HR, HRS
Human Chorionic Gonadotropin	HCG
Human Immunodeficiency Virus	HIV
Human Papilloma Virus	HPV
Human T-Lymphotrophic Virus Type III	HTLV-III
Hysterectomy	HYST
Immunoglobulin	IG
Impression	IMP
Includes, Including	INCL
Increase	INCR (or >)
Inferior Vena Cava	IVC
Infiltrating	INFILT
Inpatient	IP
Intercostal Margin	ICM
Internal Mammary Artery	IMA
Intrathecal	IT
Intravenous	IV
Intravenous Pyelogram	IVP
Iodine	I
Jugular Venous Distention	JVD
Kidneys, Ureters, Bladder	KUB

Kilogram	KG
Kilovolt	KV
Laparotomy	LAP
Left	L, LT
Left Costal Margin	LCM
Left Lower Extremity	LLE
Left Lower Lobe	LLL
Left Lower Quadrant	LLQ
Left Salpingo-oophorectomy	LSO
Left Upper Extremity	LUE
Left Upper Lobe	LUL
Left Upper Quadrant	LUQ
Liter	L
Liver, Kidney, Spleen (Bladder)	LKS(B)
Local M.D.	LMD
Lower Extremity	LE
Lower Inner Quadrant	LIQ
Lower Outer Quadrant	LOQ
Lumbar Puncture	LP
Lumbar Vertebra	L1-L5
Lumbosacral	LS
Lymphadenopathy-Associated Virus	LAV
Lymph Node(s)	LN, LN'S, LNS
Magnetic Resonance Imaging	MRI
Malignant	MALIG, MAL
Mandible	MAND
Mastectomy	MAST
Maxilla(ry)	MAX
Maximum	MAX
Medical Doctor	DR, MD
Medicine	MED
Metastatic, Metastasises	MET, METS
Microscopic	MICRO
Midclavicular Line	MCL
Middle Lobe	ML
Millicurie (hours)	MC(H)
Milligram (hours)	MG(H)
Milliliter	ML
Millimeter	mm
Million Electron Volts	MEV
Minimum	MIN
Moderate	MOD
Large	LG
Last Menstrual Period	LMP
Lateral	LAT
Moderately Differentiated	MD, MOD DIFF
Modified Radical Mastectomy	MRM
Nausea and Vomiting	N&V
Neck Vein Distention	NVD
Negative	NEG (or -)
Neurology	NEURO
No Evidence of Disease	NED
Normal	NL
No Significant Findings	NSF
Not Applicable	NA
Not Otherwise Specified	NOS
Not Recorded	NR
Obstructed (-ing, -ion)	OBST
Operating Room	OR
Operation	OP
Operative Report	OP REPORT
Ounce	OZ
Outpatient	OP
Packs per Day	PPD
Palpated (-able)	PALP
Papanicolaou Smear	PAP
Papillary	PAP
Past Medical History	PMH
Pathology	PATH
Patient	PT
Pelvic Inflammatory Disease	PID
Percussion and Auscultation	P&A
Percutaneous	PERC
Personal (Primary) Medical Doctor	PMD
Physical Examination	PE
Platelets	PLT
Poorly Differentiated	PD, POOR DIFF
Positive	POS (or +)
Positron Emission Tomography	PET
Possible	POSS
Posterior	POST
Posteroanterior	PA
Postmortem Examination	POST
Postoperative (-ly)	PO, POST OP
Postoperative Day	POD

Preoperative (-ly)	PREOP
Present Illness	PI
Prior to Admission	PTA
Probable (-ly)	PROB
Radiation Absorbed Dose	RAD
Radiation Therapy	XRT, RT
Radical	RAD
Radioimmunoassay	RIA
Radium	RA
Red Blood Cells	RBC
Resection	RESEC
Respiratory	RESPIR
Review of Outside Films	ROF
Review of Outside Slides	ROS
Review of Systems	ROS
Right	R, RT
Right Costal Margins	RCM
Right Lower Extremity	RLE
Right Lower Lobe	RLL
Right Lower Quadrant	RLQ
Right Middle Lobe	RML
Right Salpingo-oophorectomy	RSO
Right Upper Extremity	RUE
Right Upper Lobe	RUL
Right Upper Quadrant	RUQ
Rule Out	RO, R/O
Sacral Vertebra	S1-S5
Salpingo-oophorectomy	SO
Sequential Multiple Analysis (Biochem Profile)	SMA
Serum Glutamic Oxaloacetic Transaminase	SGOT
Serum Glutamic Pyruvic Transaminase	SGPT
Shortness of Breath	SOB
Skilled Nursing Facility	SNF
Specimen	SPEC
Split Thickness Skin Graft	STSG
Small	SM, SML
Small Bowel	SB, SML BWL
Spine	
Cervical	C-SPINE
Lumbar	L-SPINE
Sacral	S-SPINE
Thoracic	T-SPINE
Squamous	SQ, SQUAM
Squamous Cell Carcinoma	SCC
Status Post	S/P
Subcutaneous	SUB-Q, SUBQ, SQ
Superior Vena Cava	SVC
Surgery, Surgical	SURG
Symptoms	SX
Thoracic	T
Thoracic Vertebra	T1-T12
Total Abdominal Hysterectomy-Bilateral Salpingo-oophorectomy	
Total Parenteral Nutrition	TPN
Total Vaginal Hysterectomy	TVH
Transitional Cell Carcinoma	TCC
Transurethral Resection	TUR
Transurethral Resection Bladder (Tumor)	TURB(T)
Transurethral Resection Prostate	TURP
Treatment	RX, TX
Tumor Size	TS
Undifferentiated	UNDIFF
Upper Extremity	UE
Upper Gastrointestinal	UGI
Upper Inner Quadrant	UIQ
Upper Outer Quadrant	UOQ
Vagina, Vaginal	VAG
Vaginal Hysterectomy	VAG HYST
Vaginal Intraepithelial Neoplasia	VAIN
Vascular	VASC
Vulvar Intraepithelial Neoplasia	VIN
Well Differentiated	WD, WELL DIFF
White Blood Cells	WBC
With	W/ or C
Within Normal Limits	WNL
Without	W/O
Work-up	W/U

X-ray	XR
Year	YR

Symbols

At	@
Comparison	/
Decrease, less than	<
Equals	=
Increase, more than	>
Negative	-
Number*	#
Positive	+
Pounds**	#
Times	x

* If it appears before a numeral.
**If it appears after a numeral.

COMMON ACCEPTABLE ABBREVIATIONS

(In order of abbreviations)

ABD	Abdomen
ACID PHOS	Acid Phosphatase
A-COLON	Ascending Colon
ADENOCA	Adenocarcinoma
ADJ	Adjacent
ADM	Admission; Admit
AFP	Alpha-fetoprotein
AGL	Acute Granulocytic Leukemia
AIDS	Acquired Immunodeficiency Syndrome
AK(A)	Above Knee (Amputation)
AKA	Also Known As
ALK PHOS	Alkaline Phosphatase
ALL	Acute Lymphocytic Leukemia
AMA	Against Medical Advice
AMB	Ambulatory
AML	Acute Myelogenous Leukemia
ANAP	Anaplastic
ANGIO	Angiography
ANT	Anterior
A&P	Auscultation & Percussion
AP	Abdominal Perineal
AP	Anteroposterior
APP	Appendix
APPROX	Approximately
ARC	Aids Related Complex
ASP	Aspiration
AUT	Autopsy
AV	Arteriovenous
AX	Axilla(ry)
BA	Barium
BCG	Bacillus Calmette-Guerin
BD	Bile Duct
BE	Barium Enema
BIL	Bilateral
BK(A)	Below Knee (Amputation)
BM	Bone Marrow
BM	Bowel Movement
BPH	Benign Prostatic Hypertrophy/Hyperplasia
BRB(PR)	Bright Red Blood (per Rectum)
BRM	Biological Response Modifier
BS, BRS	Breath Sounds
BS	Bowel Sounds
BSC	Bone Scan
BSO	Bilateral Salpingo-oophorectomy
BUN	Blood Urea Nitrogen
BUS	Bartholin's, Urethral, & Skene's Glands
BX	Biopsy
C	With
C1-C7	Cervical Vertebra
CA	Calcium
CA	Carcinoma
CBC	Complete Blood Count
CBD	Common Bile Duct
CC	Chief Complaint
CC	Cubic Centimeter
CEA	Carcinoembryonic Antigen
CGL	Chronic Granulocytic Leukemia
CHEMO	Chemotherapy
CIG	Cigarettes
CIN	Cervical Intraepithelial Neoplasia
CIS	Carcinoma In Situ
CLL	Chronic Lymphocytic Leukemia
CLR	Clear
cm	Centimeter
CM	Costal Margin
CML	Chronic Myeloid Leukemia
CMV	Cytomegalovirus
CNS	Central Nervous System
C/O	Complaining of
CONT	Continue
CS	Cesium
CSF	Cerebrospinal Fluid
C-SPINE	Cervical Spine
CT, CT SC	Computerized Axial

	Tomography Scan, CAT Scan
C/W	Consistent with
CYSTO	Cystoscopy
CYTO	Cytology
D&C	Dilatation and Curettage
DC	Discontinued
D-COLON	Descending Colon
DECR (or <)	Decreased
DERM	Dermatology
DIAM	Diameter
DIFF	Differentiated
DIS	Disease
DIS, DISCH	Discharge
DOA	Dead on Arrival
DOB	Date Of Birth
DR	(Medical) Doctor
DS	Discharge
DX	Diagnosis
DZ	Disease
ECF	Extended Care Facility
EEG	Electroencephalogram
EENT	Eyes, Ears, Nose, and Throat
EGD	Esophagogastroduodenoscopy
EMG	Electromyogram
ENL	Enlarged
ENT	Ears, Nose, and Throat
ER	Emergency Room
ER(A)	Estrogen Receptor (Assay)
ERCP	Endoscopic Retrograde Cholangiopancreatography
ETOH	Alcohol
EUA	Examination under Anesthesia
EVAL	Evaluation
EXAM	Examination
EXC	Excision
EXP LAP	Exploratory Laparotomy
EXT	Extend
EXT	Extension
EXT	External
EXT	Extremity
FB	Fingerbreadth
F(M)H	Family (Medical) History
FOM	Floor of Mouth
CX	Cervix
CXR	Chest X-ray
FS	Frozen Section
FU	Follow-up
FUO	Fever Unknown Origin
FX	Fracture
GB	Gallbladder
GE	Gastroenterostomy
GE	Gastroesophageal
GI	Gastrointestinal
GM	Gram
GR	Grade
GU	Genitourinary
GYN	Gynecology
HCG	Human Chorionic Gonadotropin
HCT	Hematocrit
HEENT	Head, Eyes, Ears, Nose, Throat
HGB	Hemoglobin
HIV	Human Immunodeficiency Virus
HO	History of
HORM	Hormone
HOSP	Hospital
H&P	History and Physical
HPI	History of Present Illness
HPV	Human Papilloma Virus
HR, HRS	Hour, Hours
HTLV-III	Human T-Lymphotrophic Virus Type III
HX	History
HYST	Hysterectomy
I	Iodine
ICM	Intercostal Margin
IG	Immunoglobulin
IMA	Internal Mammary Artery
IMP	Impression
INCL	Includes, Including
INCR (or >)	Increase
INFILT	Infiltrating
IP	Inpatient
IT	Intrathecal
IV	Intravenous
IVC	Inferior Vena Cava
IVP	Intravenous Pyelogram

JVD	Jugular Venous Distention
KG	Kilogram
KUB	Kidneys, Ureters, Bladder
L1-L5	Lumbar Vertebra
LAP	Laparotomy
LAT	Lateral
LAV	Lymphadenopathy - Associated Virus
LCM	Left Costal Margin
LE	Lower Extremity
LG	Large
LIQ	Lower Inner Quadrant
LKS(B)	Liver, Kidney, Spleen (Bladder)
LLE	Left Lower Extremity
LLL	Left Lower Lobe
LLQ	Left Lower Quadrant
LMD	Local M.D.
LMP	Last Menstrual Period
LN, LN'S, LNS	Lymph Node(s)
LOQ	Lower Outer Quadrant
LP	Lumbar Puncture
LS	Lumbosacral
LSO	Left Salpingo-oophorectomy
L-SPINE	Lumbar Spine
LT	Left
LUE	Left Upper Extremity
LUL	Left Upper Lobe
LUQ	Left Upper Quadrant
MAL, MALIG	Malignant
MAND	Mandible
MAST	Mastectomy
MAX	Maxilla(ry)
MAX	Maximum
MC(H)	Millicurie(hours)
MCL	Midclavicular Line
MD	Medical Doctor
MD	Moderately Differentiated
MED	Medicine
MET, METS	Metastatic, Metastasises
MEV	Million Electron Volts
MG(H)	Milligram (hours)
MICRO	Microscopic
MIN	Minimum
ML	Middle Lobe
KV	Kilovolt
L	Left
L	Liter
ML	Milliliter
MM	Millimeter
MOD	Moderate
MOD DIFF	Moderately Differentiated
MRI	Magnetic Resonance Imaging
MRM	Modified Radical Mastectomy
NA	Not Applicable
NED	No Evidence of Disease
NEG (or -)	Negative
NEURO	Neurology
NL	Normal
NOS	Not Otherwise Specified
NR	Not Recorded
NSF	No Significant Findings
N&V	Nausea and Vomiting
NVD	Neck Vein Distention
OBST	Obstructed (-ing, -ion)
OP	Operation
OP	Outpatient
OP REPORT	Operative Report
OR	Operating Room
OZ	Ounce
P&A	Percussion and Auscultation
PA	Posteroanterior
PA	Pulmonary Artery
PALP	Palpated (-able)
PAP	Papanicolaou Smear
PAP	Papillary
PATH	Pathology
PD	Poorly Differentiated
PE	Physical Examination
PERC	Percutaneous
PET	Positron Emission Tomography
PI	Present Illness
PID	Pelvic Inflammatory Disease
PLT	Platelets
PMD	Personal (Primary) Medical Doctor
PMH	Past Medical History
PO	Postoperative (-ly)
POD	Postoperative Day

POOR DIFF	Poorly Differentiated
POS (or +)	Positive
POSS	Possible
POST	Posterior
PREOP	Preoperative (-ly)
PROB	Probable (-ly)
PT	Patient
PTA	Prior to Admission
PULM	Pulmonary
R	Right
RA	Radium
RAD	Radiation
RAD	Radiation Absorbed Dose
RAD	Radical
RBC	Red Blood Cells
RCM	Right Costal Margin
RESEC	Resection
RESPIR	Respiratory
RIA	Radioimmunoassay
RLE	Right Lower Extremity
RLL	Right Lower Lobe
RLQ	Right Lower Quadrant
RML	Right Middle Lobe
RO, R/O	Rule Out
ROF	Review of Outside Films
ROS	Review of Outside Slides
ROS	Review of Systems
RSO	Right Salpingo-oophorectomy
RT	Radiation Therapy
RT	Right
RUE	Right Upper Extremity
RUL	Right Upper Lobe
RUQ	Right Upper Quadrant
RX	Treatment
S1-S5	Sacral Vertebra
SB	Small Bowel
SCC	Squamous Cell Carcinoma
S-COLON	Sigmoid Colon
SGOT	Serum Glutamic Oxaloacetic Transaminase
SGPT	Serum Glutamic Pyruvic Transaminase
SM	Small
POST	Postmortem Examination
POSTOP	Postoperative (-ly)
PPD	Packs per Day
PR(A)	Progesterone Receptor (Assay)
SMA	Sequential Multiple Analysis (Biochem Profile)
SML	Small
SML BWL	Small Bowel
SNF	Skilled Nursing Facility
SO	Salpingo-oophorectomy
SOB	Shortness of Breath
S/P	Status Post
SPEC	Specimen
SQ	Subcutaneous
SQ, SQUAM	Squamous
S-SPINE	Sacral Spine
STSG	Split Thickness Skin Graft
SUB-Q, SUBQ	Subcutaneous
SURG	Surgery, Surgical
SVC	Superior Vena Cava
SX	Symptoms
T	Thoracic
T1-T12	Thoracic Vertebra
TAH-BSO	Total Abdominal Hysterectomy-Bilateral Salpingo-oophorectomy
TCC	Transitional Cell Carcinoma
T-COLON	Transverse Colon
TPN	Total Parenteral Nutrition
TS	Tumor Size
T-SPINE	Thoracic Spine
TUR	Transurethral Resection
TURB(T)	Transurethral Resection Bladder (Tumor)
TURP	Transurethral Resection Prostate
TVH	Total Vaginal Hysterectomy
TX	Treatment
UE	Upper Extremity
UGI	Upper Gastrointestinal
UIQ	Upper Inner Quadrant
UNDIFF	Undifferentiated
UOQ	Upper Outer Quadrant
VAG	Vagina, Vaginal
VAG HYST	Vaginal Hysterectomy

VAIN	Vaginal Intraepithelial Neoplasia
VASC	Vascular
VIN	Vulvar Intraepithelial Neoplasia
W/	With
WBC	White Blood Cells
WD, WELL DIFF	Well Differentiated
WNL	Within Normal Limits
W/O	Without
W/U	Work-up
XR	X-ray
YR	Year

Symbols

@	At
/	Comparison
<	Decrease, less than
=	Equals
>	Increase, more than
-	Negative
#	Number*
#	Pounds**
+	Positive
x	Times

* If it appears before a numeral.
** If it appears after a numeral.

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December 1996

Appendix G

Reportable Central Nervous System Tumors

REPORTABLE ICD AND ICD-O CODES
FOR CENTRAL NERVOUS SYSTEM TUMORS

ICD-O-2, ICD-O-3 & ICD-10	Subsite*	Malignant ICD-9	Benign ICD-9	Uncertain ICD-9	Benign ICD-10	Uncertain ICD-10
MENINGES						
C70.0	Cerebral meninges	192.1	225.2	237.6	D32.0	D42.0
C70.1	Spinal meninges	192.3	225.4	237.6	D32.1	D42.1
C70.9	Meninges, NOS	192.1	225.2	237.6	D32.9	D42.9
BRAIN						
C71.0	Cerebrum	191.0	225.0	237.5	D33.0	D43.0
C71.1	Frontal lobe	191.1	225.0	237.5	D33.0	D43.0
C71.2	Temporal lobe	191.2	225.0	237.5	D33.0	D43.0
C71.3	Parietal lobe	191.3	225.0	237.5	D33.0	D43.0
C71.4	Occipital lobe	191.4	225.0	237.5	D33.0	D43.0
C71.5	Ventricle, NOS	191.5	225.0	237.5	D33.0	D43.0
C71.6	Cerebellum	191.6	225.0	237.5	D33.1	D43.1
C71.7	Brain stem	191.7	225.0	237.5	D33.1	D43.1
C71.8	Overlapping lesion	191.8	225.0	237.5	D33.2	D43.2
C71.9	Brain, NOS	191.9	225.0	237.5	D33.2	D43.2
SPINAL CORD, CRANIAL NERVES AND OTHER CNS						
C72.0	Spinal cord	192.2	225.3	237.5	D33.4	D43.4
C72.1	Cauda equina	192.2	225.3	237.5	D33.4	D43.4
C72.2	Olfactory nerve	192.0	225.1	237.9	D33.3	D43.3
C72.3	Optic nerve	192.0	225.1	237.9	D33.3	D43.3
C72.4	Acoustic nerve	192.0	225.1	237.9	D33.3	D43.3
C72.5	Cranial nerve, NOS	192.0	225.1	225.1	D33.3	D43.3
C72.8	Overlapping lesion	192.8	225.9	237.9	D33.9	D43.9
C72.9	CNS, NOS	192.9	225.9	225.9	D33.9	D43.9
NEUROENDOCRINE AND RELATED STRUCTURES						
C75.1	Pituitary gland	194.3	227.3	237.0	D35.2	D44.3
C75.2	Craniopharyngeal duct (suprasellar region)	194.3	227.3	237.0	D35.3	D44.4
C75.3	Pineal gland	194.4	227.4	237.1	D35.4	D44.5

Note: The bones of the skull (C41.0) and spine (C41.2) are not part of the central nervous system. Non-malignant neoplasms arising in bone and extending into the central nervous system are not reportable.

Table was taken from the SEER “Brain Book”, Draft #2, September 2003

Appendix H

Subsequent Primaries for Hematopoietic Malignancies Diagnosed 1/2001 and Later

Appendix I

NJSCR Electronic Submission Instructions

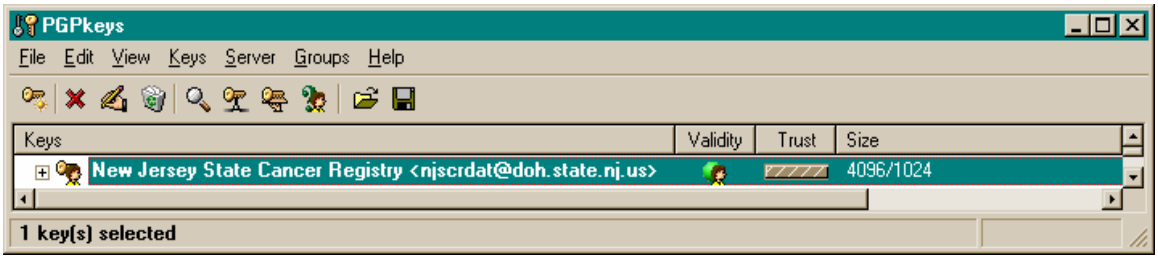
Data Submission to the NJSCR

All cancer data is submitted to the NJSCR via email with either **attached encrypted file** or with an email **link to a secure encrypted email server**. If you or your MIS department have any questions please email or call the NJSCR, address and number listed below. Export files created at New Jersey Hospitals for submission of data must meet the following criteria.

1. Files must be in NAACCR version 10 format. In 2006 data must be submitted in NAACCR format Version 11 2006.
2. Files records must be in full abstract type
3. Submitted files must either be
   a) Encrypted by "PGP" software with NJSCR provided encryption key.
   b) Placed on an approved encrypted email server such as zixmail for down load by NJSCR.
4. Encrypted files will be attached in email addressed to designated email address at NJSCR "njscrdat@doh.state.nj.us"
5. Files should be submitted on monthly basis
6. Email confirmation of receipt of data will be by return email listing file name(s), total number of records received and will be within two business days.

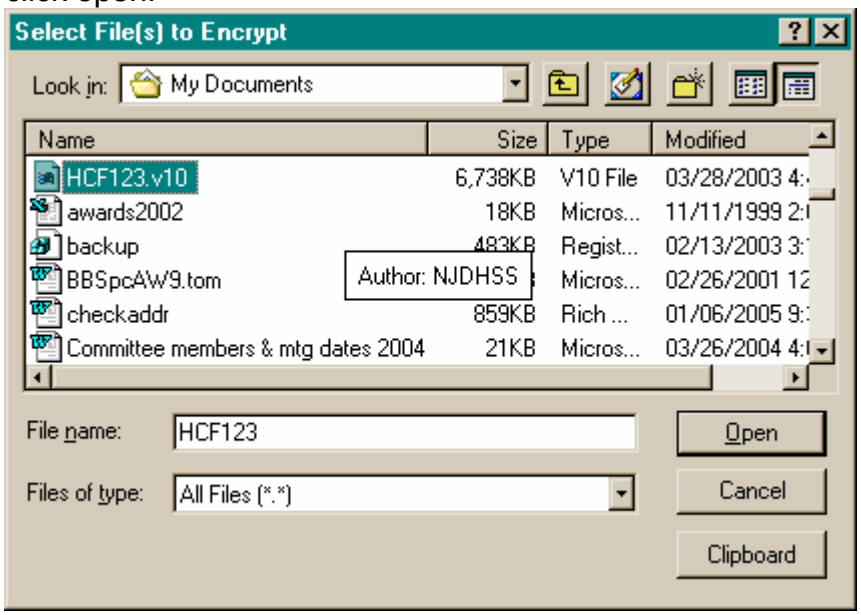
PGP Instructions

1. After purchase and installation of PGP software by hospital MIS staff the NJSCR public key sent to you must be imported into PGP

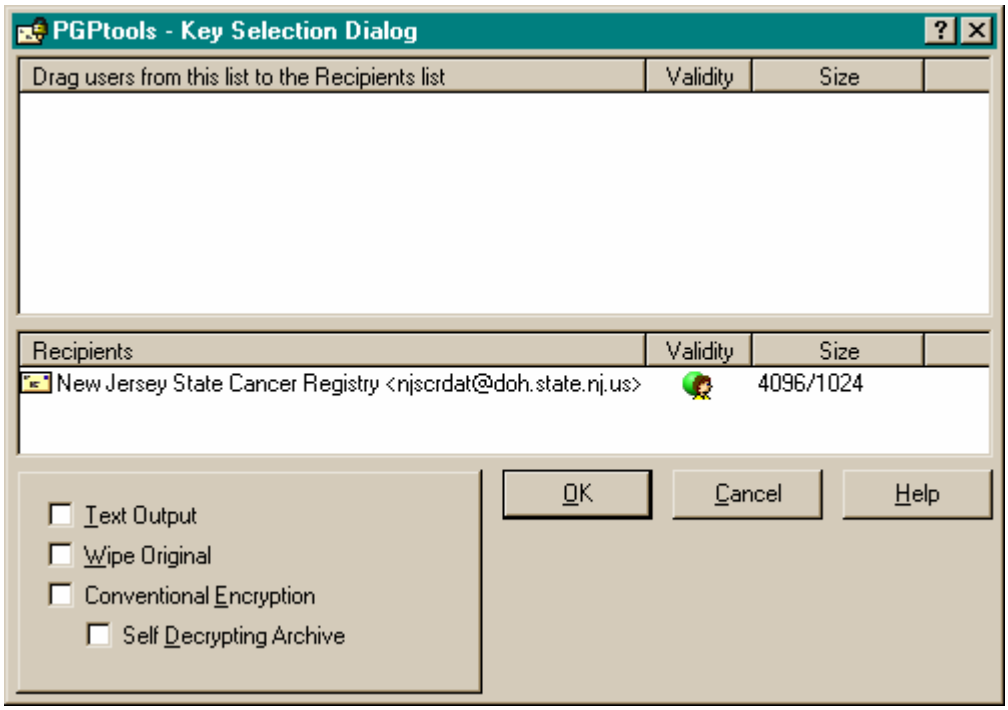


2. Export files created by your cancer data base can now be encrypted. Start PGP mail which will produce a tool bar to use in encrypting your export file. Double click on the second key from the left.

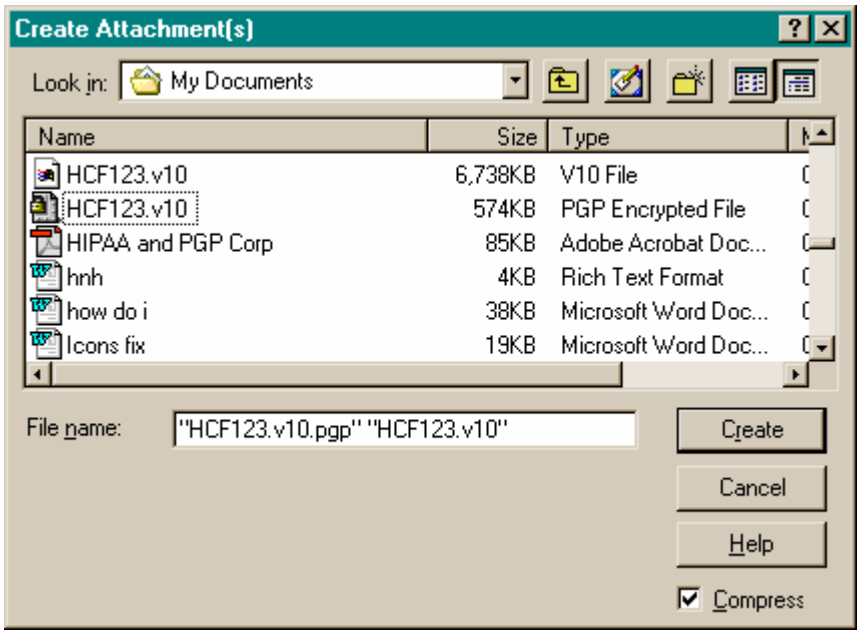
3. A file selection window will appear. You will need to know the location (path) in your cancer database to select your export file for encryption. This example uses C:\ my documents as path to select export file “HCF123.v10”. Click on file to highlight and then click open.



4. Key selection box now appears. It has upper and lower boxes. The NJSCR key must be in the lower box if it is not click on it and drag to bottom box. When key is in bottom box click OK.



5. Start your email software and address email to "njscrdat@doh.state.nj.us".
Subject line can read as monthly data submission. In the body of the email attach the encrypted export file created by PGP. This file is a compressed duplicate of your original export file and will have a different file symbol. Making an email attachment involves a windows selection box to find desired attachment. The encrypted file is in the same location as your original file (same path)



6. After creating the attachment send email.

Appendix J

Sequence Number Tables

TABLE A-1. Sequence Number: Code Assignment by Type of Neoplasm.	
***In Situ*/Malignant as Required by NJSCR Based on Diagnosis Year**	**Seq Num (Numeric Series)**
In Situ (behavior code = 2), Cervix CIS/CIN III (Diagnosis Year before 1996), Includes VIN III, VAIN III, AIN III	00-35
Malignant (Behavior Code = 3)	00-35
Juvenile Astrocytoma, Diagnosis Year 2001+*	00-35
Invasive Following *In Situ* - New Primary as Defined by CoC	00-35
Invasive Following *In Situ* - New Primary as Defined by SEER	00-35
Federally Required Sequence Number Unknown or Unspecified	99
Non-Malignant Tumors as Required Based on Diagnosis Year	**Seq Num (Numeric Series)**
Examples:	
Benign Brain YEAR 2004+	60-87
Borderline Ovarian, Diagnosis Year 2001+	60-87
Other Borderline/Benign	60-87

*Note: Per published errata, juvenile astrocytomas should be reported as 9421/3.

TABLE B. Terms Changing From Borderline (ICD-O-2) to Malignant (ICD-O-3) - Sequence Number Assignment by Diagnosis Date.

			Seq Num (Numeric Series)	
Terms Changing From: Borderlne to Malignant	**ICD-O-2**	**ICD-O-3**	**Diagnosis on or Before 12/31/2000**	**Diagnosis on or After 01/01/2001**
Endometrial Stromal Sarcoma, Low Grade (C54.1)	8931/1	8931/3	60/87	00-35
Endolymphatic Stromal Myosis (C54.1)	8931/1	8931/3	60-87	00-35
Endometrial Stromatosis (C54.1)	8931/1	8931/3	60-87	00-35
Stromal Endometriosis (C54.1)	8931/1	8931/3	60-87	00-35
Stromal Myosis, NOS (C54.1)	8931/1	8931/3	60-87	00-35
Papillary Ependymoma (C71._)	9393/1	9393/3	60-87	00-35
Papillary Meningioma	9538/1	9538/3	60-87	00-35
Polycythemia Vera	9950/1	9950/3	60-87	00-35
Polycythemia Rubra Vera	9950/1	9950/3	60-87	00-35
Chronic Myeloproliferative Disease, NOS	9960/1	9960/3	60-87	00-35
Chronic Myeloproliferative Disorder	9960/1	9960/3	60-87	00-35
Myelosclerosis with Myeloid Metaplasia	9961/1	9961/3	60-87	00-35
Megakaryocytic Myelosclerosis	9961/1	9961/3	60-87	00-35
Myelofibrosis with Myeloid Metaplasia	9961/1	9961/3	60-87	00-35
Idiopathic Thrombocythemia	9962/1	9962/3	60-87	00-35
Essential Thrombocythemia	9962/1	9962/3	60-87	00-35
Essential Hemmorhagic Thrombocythemia	9962/1	9962/3	60-87	00-35
Idiopathic Hemmorhagic Thrombocythemia	9962/1	9962/3	60-87	00-35
Refractory Anemia, NOS	9980/1	9980/3	60-87	00-35
Refractory Anemia without Sideroblasts	9981/1	9980/3	60-87	00-35
Refractory Anemia with Sideroblasts	9982/1	9982/3	60-87	00-35
Refractory Anemia with Ringed Sideroblasts	9982/1	9982/3	60-87	00-35
Refractory Anemia with Excess Blasts	9983/1	9983/3	60-87	00-35
Refractory Anemia with Excess Blasts in Transformation	9984/1	9984/3	60-87	00-35
Myelodysplastic Syndrome, NOS	9989/1	9989/3	60-87	00-35
Preleukemia	9989/1	9989/3	60-87	00-35
Preleukemic Syndrome	9989/1	9989/3	60-87	00-35

TABLE C. Terms Changing From Malignant (ICD-O-2) to Borderline (ICD-O-3) - Sequence Number Assignment by Diagnosis Date.				
			Seq Num (Numeric Series)	
Terms Changing From: Malignant to Borderline	**ICD-O-2**	**ICD-O-3**	**Diagnosis on or Before 12/31/2000**	**Diagnosis on or After 01/01/2001**
Serous Cystadenoma, Borderline Malignancy (C56.9)	8442/3	8442/1	00-35	60-87
Serous Tumor, NOS, of Low Malignant Potential (56.9)	8442/3	8442/1	00-35	60-87
Papillary Cystadenoma, Borderline Malignancy (C56.9)	8451/3	8451/1	00-35	60-87
Serous Papillary Cystic Tumor of Borderline Malignancy (C56.9)	8462/3	8462/1	00-35	60-87
Papillary Serous Cystadenoma, Bordelrine Malignancy (C56.9)	8462/3	8462/1	00-35	60-87
Papillary Serous Tumor of Low Malignant Potential (C56.9)	8462/3	8462/1	00-35	60-87
Atypical Proliferative Papillary Serous Tumor (C56.9)	8462/3	8462/1	00-35	60-87
Mucinous Cystic Tumor of Borderline Malignancy (56.9)	8472/3	8472/1	00-35	60-87
Mucinous Cystadenoma, Borderline Malignancy (C56.9)	8472/3	8472/1	00-35	60-87
Pseudomucinous Cystadenoma, Borderline Malignancy (C56.9)	8472/3	8472/1	00-35	60-87
Mucinous Tumor, NOS, of Low Malignant Potential (56.9)	8472/3	8472/1	00-35	60-87
Papillary Mucinous Cystadenoma, Borderline Malignancy (C56.9)	8473/3	8473/1	00-35	60-87
Papillary Pseudomucinous Cystadenoma, Borderline Malignancy (C56.9)	8473/3	8473/1	00-35	60-87
Papillary Mucinous Tumor of Low Malignant Potential (C56.9)	8473/3	8473/1	00-35	60-87
Pilocytic Astrocytoma (C71._)*	9421/3	9421/3	00-35	00-35
Piloid Astrocytoma (C71._)*	9421/3	9421/3	00-35	00-35
Juvenile Astrocytoma (C71._)*	9421/3	9421/3	00-35	00-35
Spongioblastoma, NOS (C71/_) [obs.]*	9422/3	9421/3	00-35	00-35

*Note: ICD-0-3 now classifies this diagnosis as "borderline;" however, by agreement in North America, the diagnosis still is coded as "malignant."

TABLE D. Terms Changing From Benign (ICD-O-2) to Borderline (ICD-O-3) - Sequence Number Assignment by Diagnosis Date.				
			Seq Num (Numeric Series)	
Terms Changing From: Benign to Borderline	**ICD-O-2**	**ICD-O-3**	**Diagnosis on or Before 12/31/2000**	**Diagnosis on or After 01/01/2001**
Transitional Cell Papilloma, NOS	8120/0	8120/1	60-87	60-87
Glucagonoma, NOS (25._)	8152/0	8152/1	60-87	60-87
Thymoma, NOS (37.9)	8580/0	8580/1	60-87	60-87
Sertoli Cell Tumor, NOS	8640/0	8640/1	60-87	60-87
Pick Tubular Adenoma	8640/0	8640/1	60-87	60-87
Sertoli Cell Adenoma	8640/0	8640/1	60-87	60-87
Tubular Androblastoma, NOS	8640/0	8640/1	60-87	60-87
Testicular Adenoma	8640/0	8640/1	60-87	60-87
Neurocytoma	9506/0	9506/1	60-87	60-87

TABLE E. Terms Changing From Borderline (ICD-O-2) to Benign (ICD-O-3) - Sequence Number Assignment by Diagnosis Date.				
			Seq Num (Numeric Series)	
Terms Changing From: Borderline to Benign	**ICD-O-2**	**ICD-O-3**	**Diagnosis on or Before 12/31/2000**	**Diagnosis on or After 01/01/2001**
Villous Adenoma, NOS	8261/1	8261/0	60-87	60-87
Villous Papilloma	8261/1	8261/0	60-87	60-87
Juxtaglomerular Tumor (C64.9)	8361/1	8361/0	60-87	60-87
Reninoma (C64.9)	8361/1	8361/0	60-87	60-87
Desmoplastic Fibroma	8823/1	8823/0	60-87	60-87
Mature Teratoma	9080/1	9080/0	60-87	60-87

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TABLE F. Reportable Central Nervous System Tumors Diagnosis Year 01/01/04 and After.		
Terms Borderline or Benign	**ICD-O-3**	**Sequence Number**
Acoustic neuroma (O)	9560/0	60-87
Angiolipoma (O)	8861/0	60-87
Angiomatous meningioma (O)	9534/0	60-87
Atypical choroids plexus papilloma (+)	9390/1	60-87
Atypical lipoma (+)	8850/1	60-87
Atypical meningioma (+)	9593/1	60-87
Capillary hemangioma (O)	9131/0	60-87
Cavernous hemangioma (O)	9121/0	60-87
Central neurocytoma (+)	9506/1	60-87
Chordoid glioma (+)	9444/1	60-87
Choroid plexus papilloma (O)	9390/0	60-87
Clear cell meningioma (+)	9538/1	60-87
Dermoid cyst (O)	9084/0	60-87
Desmoplastic infantile astrocytoma (+)	9412/1	60-87
Diffuse melanocytosis (O)	8728/0	60-87
Dysembryoplastic neuroepithelial tumor (O)	9413/0	60-87
Dysplastic gangliocytoma of cerebellum (O)	9493/0	60-87

Fibrolipoma (O)	8851/0	60-87
Fibroma (O)	8810/0	60-87
Fibrous meningioma (O)	9532/0	60-87
Gangliocytoma (O)	9492/0	60-87
Ganglioglioma (+)	9505/1	60-87
Ganglioneuroma (O)	9490/0	60-87
Gliofibroma (+)	9442/1	60-87
Hemangioblastoma (+)	9161/1	60-87
Hemangioendothelioma, benign (O)	9130/0	60-87
Hemangioendothelioma (+)	9130/1	60-87
Hemangioma (O)	9120/0	60-87
Hemangiopericytoma, benign (O)	9150/0	60-87
Hemangiopericytoma (+)	9150/1	60-87
Leiomyoma (O)	8890/0	60-87
Leiomyomatosis (+)	8890/1	60-87
Lipoma (O)	8850/0	60-87
Medulloepithelioma (O)	9501/0	60-87
Melanotic neurofibroma (O)	9541/0	60-87
Meningeal melancytoma (+)	8728/1	60-87
Meningioma (O)	9530/0	60-87
Meningiomatosis (+)	9530/1	60-87
Meningiotheliomatous meningioma (O)	9531/0	60-87
Meningiothelial meningioma (O)	9531/0	60-87
Myxopapillary ependymoma (+)	9394/1	60-87
Neoplasm, benign(O)	8000/0	60-87
Neoplasm, uncertain if benign or malignant (+)	8000/1	60-87
Neurilemoma (O)	9560/0	60-87
Neuriomatosis (+)	9560/1	60-87
Neurofibroma (O)	9540/0	60-87
Neurofibromatosis	9540/1	60-87
Neuroma (O)	9570/0	60-87
Neurothekeoma (O)	9562/0	60-87
Paraganglioma (+)	8680/1	60-87
Perineurioma (O)	9571/0	60-87
Plexiform neurofibroma (O)	9550/0	60-87
Psammomatous meningioma (O)	9533/0	60-87
Rhabdomyoma (O)	8900/0	60-87
Schwannoma (any)	9560/0	60-87
Smooth muscle tumor (+)	8897/1	60-87
Soft tissue tumor, benign (O)	8800/0	60-87
Solitary fibrous tumor (O)	8815/0	60-87
Subependymal giant cell astrocytoma (+)	9384/1	60-87
Subependymoma (+)	9383/1	60-87
Teratoma benign (o)	9080/0	60-87
Teratoma (+)	9080/1	60-87
Transitional meningioma (O)	9537/0	60-87
Tumor cells, benign (O)	8001/0	60-87
Venous hemangioma (O)	9122/0	60-87
PINEAL Dermoid cyst (O)	9084/0	60-87

Epithelial tumor, benign (O)	8010/0	60-87
Gangliocytoma (O)	9492/0	60-87
Ganglioglioma (+)	9505/1	60-87
Neoplasm, benign (O)	8000/0	60-87
Pinealoma (+)	9360/1	60-87
Pineocytoma (+)	9361/1	60-87
Teratoma, benign (O)	9080/0	60-87
Teratoma (+)	9080/1	60-87
PITUITARY/CRANIOPHARYNGEAL DUCT		
Acidophil adenoma (O)	8280/0	60-87
Adamanthinomatous craniophyngioma (+)	9351/1	60-87
Adenoma (O)	8140/0	60-87
Basophil adenoma (O)	8300/0	60-87
Chromophobe adenoma (O)	8270/0	60-87
Clear cell adenoma (O)	8310/0	60-87
Clear cell tumor (O)	8005/0	60-87
Craniopharyngioma (any type) (+)	9350/1	60-87
Epithelial tumor, benign (O)	8010/0	60-87
Granular cell tumor (O)	9580/0	60-87
Lipoma (O)	8850/0	60-87
Mixed acidophil-basophil adenoma (O)	8281/0	60-87
Mixed cell adenoma (O)	8323/0	60-87
Monomorphic adenoma (O)	8146/0	60-87
Neoplasm, uncertain (+)	8000/1	60-87
Neoplasm, benign (O)	8000/0	60-87
Oxyphilic adenoma (O)	8290/0	60-87
Papillary adenoma (O)	8260/0	60-87
Papillary craniopharyngioma (+)	9352/1	60-87
Pituitary adenoma (O)	8272/0	60-87
Prolactinoma (O)	8271/0	60-87
Rathke pouch tumor (+)	9350/1	60-87
Soft tissue tumor, benign (O)	8800/0	60-87
Teratoma, benign (O)	9080/0	60-87
Teratoma (+)	9080/1	60-87
Tumor cells, benign or uncertain (+)	8001/1	60-87
PARAGANGLIA		
Nonchromaffin paraganglioma (+)	8693/1	60-87

0 = benign
+ = borderline

Appendix K

Required Data Item Table
NAACCR Volume II, Version 11 for NJSCR

Item #	Item Name	NJSCR Collect
10	Record Type	
20	Patient ID Number	R#
30	Registry Type	
35	FIN Coding System	
37	Reserved 00	
40	Registry ID	R#
50	NAACCR Record Version	R#
60	Tumor Record Number	R#
70	Addr at DX--City	R
80	Addr at DX--State	R
90	County at DX	R
100	Addr at DX--Postal Code	R
110	Census Tract 1970/80/90	
120	Census Cod Sys 1970/80/90	
130	Census Tract 2000	R#
140	Census Tract Cod Sys--Alt	
150	Marital Status at DX	R
160	Race 1	R
161	Race 2	R
162	Race 3	R
163	Race 4	R
164	Race 5	R
170	Race Coding Sys--Current	
180	Race Coding Sys--Original	
190	Spanish/Hispanic Origin	R
191	NHIA Derived Hisp Origin	R#
192	IHS Link	R#
200	Computed Ethnicity	R#
210	Computed Ethnicity Source	R#
220	Sex	R
230	Age at Diagnosis	R
240	Birth Date	R
250	Birthplace	R
260	Religion	
270	Occupation Code--Census	
280	Industry Code--Census	
290	Occupation Source	
300	Industry Source	
310	Text--Usual Occupation	R*
320	Text--Usual Industry	R*
330	Occup/Ind Coding System	
340	Tobacco History	
350	Alcohol History	
360	Family History of Cancer	
362	Census Tract Block Group	
364	Census Tr Cert 1970/80/90	RH
365	Census Tr Certainty 2000	R#
366	GIS Coordinate Quality	R#
370	Reserved 01	
380	Sequence Number--Central	R#
390	Date of Diagnosis	R
400	Primary Site	R
410	Laterality	R
419	Morph--Type & Behav ICD-O-2	
420	Histology (92-00) ICD-O-2	RH
430	Behavior (92-00) ICD-O-2	RH
440	Grade	R
442	Ambiguous Terminology DX	R
443	Date of Conclusive DX	R
444	Multi Tum Rpt as One Prim	R
445	Date of Multiple Tumors	R
446	Multiplicity Counter	R#
447	Number of Tumors/Hist	R
450	Site Coding Sys--Current	
460	Site Coding Sys--Original	
470	Morph Coding Sys--Current	
480	Morph Coding Sys--Original	
490	Diagnostic Confirmation	R
500	Type of Reporting Source	R
501	Casefinding Source	R
510	Screening Date	
520	Screening Result	
521	Morph--Type & Behav ICD-O-3	
522	Histologic Type ICD-O-3	R
523	Behavior Code ICD-O-3	R
530	Reserved 02	
538	Reporting Hospital FAN	
540	Reporting Hospital	R
550	Accession Number--Hosp	R
560	Sequence Number--Hospital	R
570	Abstracted By	R
580	Date of 1st Contact	R*
590	Date of Inpatient Adm	R*
600	Date of Inpatient Disch	R*
610	Class of Case	RC
620	Year First Seen This CA	R*
630	Primary Payer at DX	R*
640	Inpatient/Outpt Status	R*
650	Presentation at CA Conference	R*
660	Date of CA Conference	R*
670	RX Hosp--Surg Prim Site	R
672	RX Hosp--Scope Reg LN Sur	R
674	RX Hosp--Surg Oth Reg/Dis	R
676	RX Hosp--Reg LN Removed	R*
680	Reserved 03	
690	RX Hosp—Radiation	R
700	RX Hosp—Chemo	R
710	RX Hosp—Hormone	R
720	RX Hosp—BRM	R
730	RX Hosp—Other	R
740	RX Hosp--DX/Stg Proc	
742	RX Hosp--Screen/BX Proc 1	
743	RX Hosp--Screen/BX Proc 2	
744	RX Hosp--Screen/BX Proc 3	
745	RX Hosp--Screen/BX Proc 4	
746	RX Hosp--Surg Site 00-02	RH/R
747	RX Hosp--Scope Reg 00-02	RH/R
748	RX Hosp--Surg Oth 00-02	RH/R
750	Reserved 04	
759	SEER Summary Stage 2000	RH
760	SEER Summary Stage 1977	RH
770	Loc/Reg/Distant Stage	
779	Extent of Disease 10-Dig	
780	EOD--Tumor Size	RH
790	EOD—Extension	RH
800	EOD--Extension Prost Path	RH
810	EOD--Lymph Node Involv	RH
820	Regional Nodes Positive	R
830	Regional Nodes Examined	R

840	EOD--Old 13 Digit	
850	EOD--Old 2 Digit	
860	EOD--Old 4 Digit	
870	Coding System of EOD	R#
880	TNM Path T	R*
890	TNM Path N	R*
900	TNM Path M	R*
910	TNM Path Stage Group	R*
920	TNM Path Descriptor	R*
930	TNM Path Staged By	R*
940	TNM Clin T	R*
950	TNM Clin N	R*
960	TNM Clin M	R*
970	TNM Clin Stage Group	R*
980	TNM Clin Descriptor	R*
990	TNM Clin Staged By	R*
1000	TNM Other T	
1010	TNM Other N	
1020	TNM Other M	
1030	TNM Other Stage Group	
1040	TNM Other Staged By	
1050	TNM Other Descriptor	
1060	TNM Edition Number	R*
1070	Other Staging System	
1080	Date of 1st Positive BX	
1090	Site of Distant Met 1	R*
1100	Site of Distant Met 2	R*
1110	Site of Distant Met 3	R*
1120	Pediatric Stage	
1130	Pediatric Staging System	
1140	Pediatric Staged By	
1150	Tumor Marker 1	RH
1160	Tumor Marker 2	RH
1170	Tumor Marker 3	RH
1180	Reserved 05	
1190	Reserved 06	
1200	RX Date--Surgery	R
1210	RX Date--Radiation	R
1220	RX Date--Chemo	R
1230	RX Date--Hormone	R
1240	RX Date--BRM	R
1250	RX Date--Other	R
1260	Date of Initial RX--SEER	R
1270	Date of 1st Crs RX--COC	
1280	RX Date--DX/Stg Proc	
1290	RX Summ--Surg Prim Site	R
1292	RX Summ--Scope Reg LN Sur	R
1294	RX Summ--Surg Oth Reg/Dis	R
1296	RX Summ--Reg LN Examined	RH
1300	Reserved 07	
1310	RX Summ--Surgical Approch	
1320	RX Summ--Surgical Margins	
1330	RX Summ--Reconstruct 1st	RH
1340	Reason for No Surgery	R
1350	RX Summ--DX/Stg Proc	
1360	RX Summ--Radiation	R
1370	RX Summ--Rad to CNS	RH
1380	RX Summ--Surg/Rad Seq	R
1390	RX Summ--Chemo	R
1400	RX Summ--Hormone	R

1410	RX Summ--BRM	R
1420	RX Summ--Other	R
1430	Reason for No Radiation	S
1440	Reason for No Chemo	
1450	Reason for no Hormone	
1460	RX Coding System--Current	R#
1470	Protocol Eligibility Stat	
1480	Protocol Participation	
1490	Referral to Support Serv	
1500	First Course Calc Method	
1510	Rad--Regional Dose: cGy	
1520	Rad--No of Treatment Vol	
1530	Rad--Elapsed RX Days	
1540	Rad--Treatment Volume	
1550	Rad--Location of RX	
1560	Rad--Intent of Treatment	
1570	Rad--Regional RX Modality	R
1580	Rad--RX Completion Status	
1590	Rad--Local Control Status	
1600	Chemotherapy Field 1	
1610	Chemotherapy Field 2	
1620	Chemotherapy Field 3	
1630	Chemotherapy Field 4	
1639	RX Summ--Systemic Sur Seq	R
1640	RX Summ--Surgery Type	RH
1642	RX Summ--Screen/BX Proc 1	
1643	RX Summ--Screen/BX Proc 2	
1644	RX Summ--Screen/BX Proc 3	
1645	RX Summ--Screen/BX Proc 4	
1646	RX Summ--Surg Site 00-02	RH
1647	RX Summ--Scope Reg 00-02	RH
1648	RX Summ--Surg Oth 00-02	RH
1650	Reserved 08	
1660	Subsq RX 2nd Course Date	
1670	Subsq RX 2nd Course Codes	
1671	Subsq RX 2nd Course Surg	
1672	Subsq RX 2nd Course Rad	
1673	Subsq RX 2nd Course Chemo	
1674	Subsq RX 2nd Course Horm	
1675	Subsq RX 2nd Course BRM	
1676	Subsq RX 2nd Course Oth	
1677	Subsq RX 2nd--Scope LN SU	
1678	Subsq RX 2nd--Surg Oth	
1679	Subsq RX 2nd--Reg LN Rem	
1680	Subsq RX 3rd Course Date	
1690	Subsq RX 3rd Course Codes	
1691	Subsq RX 3rd Course Surg	
1692	Subsq RX 3rd Course Rad	
1693	Subsq RX 3rd Course Chemo	
1694	Subsq RX 3rd Course Horm	
1695	Subsq RX 3rd Course BRM	
1696	Subsq RX 3rd Course Oth	
1697	Subsq RX 3rd—Scope LN SU	
1698	Subsq RX 3rd--Surg Oth	
1699	Subsq RX 3rd--Reg LN Rem	
1700	Subsq RX 4th Course Date	
1710	Subsq RX 4th Course Codes	
1711	Subsq RX 4th Course Surg	
1712	Subsq RX 4th Course Rad	
1713	Subsq RX 4th Course Chemo	

1714	Subsq RX 4th Course Horm	
1715	Subsq RX 4th Course BRM	
1716	Subsq RX 4th Course Oth	
1717	Subsq RX 4th—Scope LN SU	
1718	Subsq RX 4th--Surg Oth	
1719	Subsq RX 4th--Reg LN Rem	
1720	Subsq RX 5th Course Date	
1730	Subsq RX 5th Course Codes	
1731	Subsq RX 5th Course Surg	
1732	Subsq RX 5th Course Rad	
1733	Subsq RX 5th Course Chemo	
1734	Subsq RX 5th Course Horm	
1735	Subsq RX 5th Course BRM	
1736	Subsq RX 5th Course Oth	
1737	Subsq RX 5th--Scope LN SU	
1738	Subsq RX 5th--Surg Oth	
1739	Subsq RX 5th--Reg LN Rem	
1740	Reserved 09	
1741	Subsq RX--Reconstruct Del	
1750	Date of Last Contact	R
1760	Vital Status	R
1770	Cancer Status	R*
1780	Quality of Survival	
1790	Follow-up Source	R*
1791	Follow-up Source Central	R#
1800	Next Follow-up Source	R*
1810	Addr Current--City	R
1820	Addr Current-State	R
1830	Addr Current--Postal Code	R
1835	Reserved 10	
1840	County--Current	
1842	Follow-up Contact--City	R
1844	Follow-up Contact--State	R
1846	Follow-up Contact--Postal	R
1850	Unusual Follow-up Method	
1860	Recurrence Date--1st	RC
1871	Recurrence Distant Site 1	
1872	Recurrence Distant Site 2	
1873	Recurrence Distant Site 3	
1880	Recurrence Type--1st	RC
1890	Recurrence Type--1st--Oth	
1900	Reserved 11	
1910	Cause of Death	R*
1920	ICD Revision Number	R#
1930	Autopsy	
1940	Place of Death	
1950	Reserved 12	
1960	Site (73-91) ICD-O-1	RH
1970	Morph (73-91) ICD-O-1	
1971	Histology (73-91) ICD-O-1	RH
1972	Behavior (73-91) ICD-O-1	RH
1973	Grade (73-91) ICD-O-1	RH
1980	ICD-O-2 Conversion Flag	RH#
1981	Over-ride SS/Nodes Pos	
1982	Over-ride SS/TNM-N	
1983	Over-ride SS/TNM-M	
1984	Over-ride SS/DisMet 1	
1985	Over-ride Acsn/Class/Seq	
1986	Over-ride Hosp Seq/DX Conf	
1987	Over-ride COC-Site/Type	

1988	Over-ride Hosp Seq/Site	
1989	Over-ride Site/TNM-Stg Grp	
1990	Over-ride Age/Site/Morph	R
2000	Over-ride Seq No/DX Conf	R
2010	Over-ride Site/Lat/Seq No	R
2020	Over-ride Surg/DX Conf	R
2030	Over-ride Site/Type	R
2040	Over-ride Histology	R
2050	Over-ride Report Source	R
2060	Over-ride Ill-define Site	R
2070	Over-ride Leuk, Lymphoma	R
2071	Over-ride Site/Behavior	R
2072	Over-ride Site/EOD/DX Dt	R
2073	Over-ride Site/Lat/EOD	R
2074	Over-ride Site/Lat/Morph	R
2081	CRC CHECKSUM	
2090	Date Case Completed	
2100	Date Case Last Changed	
2110	Date Case Report Exported	R#
2111	Date Case Report Received	
2112	Date Case Report Loaded	
2113	Date Tumor Record Availabl	
2114	Future Use Timeliness 1	
2115	Future Use Timeliness 2	
2116	ICD-O-3 Conversion Flag	R#
2120	SEER Coding Sys--Current	
2130	SEER Coding Sys--Original	
2140	COC Coding Sys--Current	
2150	COC Coding Sys--Original	
2160	Subsq Report for Primary	
2161	Reserved 20	
2170	Vendor Name	
2180	SEER Type of Follow-up	R#
2190	SEER Record Number	R#
2200	Diagnostic Proc 73-87	
2210	Reserved 14	
2220	State/Requestor Items	
2230	Name—Last	R
2240	Name—First	R
2250	Name—Middle	R
2260	Name—Prefix	
2270	Name—Suffix	R
2280	Name—Alias	R
2290	Name--Spouse/Parent	
2300	Medical Record Number	R
2310	Military Record No Suffix	
2320	Social Security Number	R
2330	Addr at DX--No & Street	R
2335	Addr at DX--Supplementl	
2350	Addr Current--No & Street	R
2352	Latitude	
2354	Longitude	
2355	Addr Current--Supplemntl	
2360	Telephone	R
2370	DC State	
2371	Reserved for Expansion	
2380	DC State File Number	
2390	Name—Maiden	R
2392	Follow-up Contact--No & St	R
2393	Follow-up Contact--Suppl	

2394	Follow-up Contact--Name	R
2400	Reserved 16	
2410	Institution Referred From	
2420	Institution Referred To	
2430	Last Follow-up Hospital	R*
2440	Following Registry	R
2450	Reserved 17	
2460	Physician--Managing	
2470	Physician--Follow-up	R
2480	Physician--Primary Surg	R*
2490	Physician 3	R*
2500	Physician 4	R*
2520	Text--DX Proc--PE	R
2530	Text--DX Proc--X-ray/Scan	R
2540	Text--DX Proc--Scopes	R
2550	Text--DX Proc--Lab Tests	R
2560	Text--DX Proc--Op	R
2570	Text--DX Proc--Path	R
2580	Text--Primary Site Title	R
2590	Text--Histology Title	R
2600	Text--Staging	R
2610	RX Text--Surgery	R
2620	RX Text--Radiation (Beam)	R
2630	RX Text--Radiation Other	R
2640	RX Text--Chemo	R
2650	RX Text--Hormone	R
2660	RX Text--BRM	R
2670	RX Text--Other	R
2680	Text--Remarks	R
2690	Place of Diagnosis	R
2700	Reserved 19	
2800	CS Tumor Size	R
2810	CS Extension	R
2820	CS Tumor Size/Ext Eval	R
2830	CS Lymph Nodes	R
2840	CS Reg Nodes Eval	R
2850	CS Mets at DX	R
2860	CS Mets Eval	R
2880	CS Site-specific Factor 1	R
2890	CS Site-specific Factor 2	R
2900	CS Site-specific Factor 3	R
2910	CS Site-specific Factor 4	R
2920	CS Site-specific Factor 5	R
2930	CS Site-specific Factor 6	R
2940	Derived AJCC T	
2950	Derived AJCC T Descriptor	
2960	Derived AJCC N	
2970	Derived AJCC N Descriptor	
2980	Derived AJCC M	
2990	Derived AJCC M Descriptor	
3000	Derived AJCC Stage Group	
3010	Derived SS1977	
3020	Derived SS2000	
3030	Derived AJCC--Flag	
3040	Derived SS 1977--Flag	
3050	Derived SS2000--Flag	
3100	Archive FIN	R#
3110	Comorbid/Complication 1	R*
3120	Comorbid/Complication 2	R*
3130	Comorbid/Complication 3	R*
3140	Comorbid/Complication 4	R*
3150	Comorbid/Complication 5	R*
3160	Comorbid/Complication 6	R*
3170	RX Date--Most Defin Surg	R*
3180	RX Date--Surgical Disch	R*
3190	Readm Same Hosp 30 Days	R*
3200	Rad--Boost RX Modality	R
3210	Rad--Boost Dose cGy	R*
3220	RX Date--Radiation Ended	R*
3230	RX Date—Systemic	R*
3250	RX Summ--Transplnt/Endocr	R*
3260	Pain Assessment	R*
3270	RX Summ--Palliative Proc	R*
3280	RX Hosp--Palliative Proc	R*
3300	Rural Urban Continuum 1993	
3310	Rural Urban Continuum 2000	

Appendix L

ICD-O-3 Combined and Mixed Histology Codes

CODING COMPLEX MORPHOLOGIC DIAGNOSES

Effective for cases coded with ICD-O-3 diagnosed 01/01/2001 and after

Definition: Complex Morphology

- Diagnoses that challenge the usual rules
- Different cell types in one tumor
- Different subtypes of the same basic cell type
- Codes that can be used to identify tumors with multiple histologic entities

What's the Problem?

- Pathologists' use of 'category terms' like duct cell carcinoma and renal cell carcinoma
- Pathologists' use of 'mixed' to mean different things
- Pathologists' use of 'type' and 'subtype' interchangeably
- Registrars aren't pathologists

What's the Solution?

Combination codes

- Reduce overcounting of primary cancers
- Flag specific situations rather than losing them in an NOS code
- Are useful but require additional skills to use

Terminology

- In most cases, mixed = combined. Sometimes 'mixed' indicates a unique tumor, not a combination.
- 'Type' can be a
  - different cell
  - variant of the same cell
  - subset of a more generic term
- Terms are used interchangeably
- Collision tumor: two separate primaries that grow together

NOS vs. Complex code

- Meaning of NOS
  - Not Otherwise Specified
  - Not Elsewhere Classified
  - Term used in a general sense
- Complex codes
  - Sometimes a category rather than a specific histologic diagnosis

CODING MORPHOLOGY FOR SINGLE PRIMARIES (ALL SITES)

Coding mixed or multiple morphologies in a single primary

Apply these rules in priority order:

- A. Use a combination code
  - 8255/3 Renal cell carcinoma, mixed clear cell and chromophobe types
  - 8523/_ Infiltrating duct carcinoma mixed with other types of carcinoma
  - 8524/_ Infiltrating lobular carcinoma mixed with other types of carcinoma

- B. Code the more specific morphology
  - Non-specific morphologies:
    - _ carcinoma, adenocarcinoma, melanoma, sarcoma
  - *Example:* Poorly differentiated carcinoma, probably squamous in origin
    - Code to 8070/3 Squamous cell carcinoma

- C1. Code the majority of the tumor
  - If the diagnosis is "generic cancer of something type," code the type.
  - *Example:* Duct carcinoma, cribriform type
    - Code to: 8201/3 Cribriform carcinoma

C2. Code majority of tumor based on "majority words"

- Majority words
  - Predominantly
  - "type"
  - "with features of"
  - "with ... differentiation"
- NOT majority words
  - "with foci of"
  - "with areas of"
  - "with elements of"

- D. Code the morphology with the highest code
  - Used infrequently—rule with lowest priority
  - *Example:* Pleural tumor containing malignant mesothelioma (9050) and neuroendocrine carcinoma (8246)
    - Code to 9050/3 Malignant mesothelioma

REMEMBER ICD-O-3 RULE F (**The Matrix Principle)**

☞ **Use the appropriate 5th digit behavior code even if the exact term is not listed in ICD-O.**

Example: if all the mixed tissue is *in situ*, it is OK to change a combination code listed in ICD-O-3 with a behavior of /3 to /2.

CODING COMPLEX BREAST HISTOLOGIES

Apply these guidelines in priority order. Use the first guideline that applies and stop.

Single Tumors with Complex Histology

1. If the diagnosis is both lobular and ductal (in situ or invasive or a combination), use code 8522.
   Examples: Duct carcinoma and lobular carcinoma in situ -- code as 8522/3.
   LCIS and DCIS -- code as 8522/2.

2. If the diagnosis is mixed invasive and in situ, code the invasive diagnosis.
   Examples: Ductal carcinoma with extensive cribriforming DCIS -- code as 8500/3
   Mucinous carcinoma in a background of ductal carcinoma in situ -- code as 8480/3
   Infiltrating ductal carcinoma with DCIS, solid, cribriform and comedo type – code as ductal carcinoma, 8500/3.

3. Use a combination code if the diagnosis is duct carcinoma or lobular carcinoma mixed with another type of carcinoma.
   Look for "and" or "mixed" in the diagnosis.
   a. If the diagnosis is duct carcinoma mixed with another type of carcinoma (excluding lobular), use code 8523/_.
      Examples: Duct carcinoma **and** tubular carcinoma – code as 8523/3.
      DCIS and cribriform carcinoma in situ -- code as 8523/2
   b. If the diagnosis is lobular carcinoma mixed with another type of carcinoma (excluding ductal), use code 8524.
      Examples: Lobular and adenoid cystic carcinoma -- code as 8524/3
      Tubular carcinoma and lobular carcinoma -- code as 8524/3

4. Code the specific type if the diagnosis is
   · Duct carcinoma, _____ type
   · Duct carcinoma, predominantly _____
   · Duct carcinoma with features of _____
   Code the stated type (subtype) even if the code is lower than 8500.
   Look for the term "type," "subtype," or "variant" or terms that indicate the majority of the tumor.
   Examples: Duct carcinoma, tubular type -- code as tubular carcinoma, 8211
   Duct carcinoma with apocrine features -- code as apocrine carcinoma, 8401/3

5. If the diagnosis includes more than one subtype, use a combination code.
   Examples: Duct carcinoma, cribriform and comedo types – code as 8523/3.
   Duct carcinoma in situ, showing both solid and cribriforming subtypes -- code as 8523/2

Separate Tumors of Different Histologies in One Breast

6. If different histologies occur in separate tumors in the same breast, use a combination code if possible and count the case as a single primary.
   Examples: LCIS UIQ right breast and duct carcinoma LIQ -- code as 8522/3
   Paget disease of nipple and intraductal carcinoma, UOQ -- code as 8543/3

HISTOLOGY CODES FOR INVASIVE BREAST CANCERS

Histology code must reflect the invasive tumor; terms include invasion, infiltrating, infiltration

I. Invasive only, single type, no in situ component	
Invasive carcinoma	8010/3
Invasive adenocarcinoma	8140/3
Invasive ductal (duct) carcinoma	8500/3
Invasive lobular carcinoma (NOS and subtypes)	8520/3
Tubular carcinoma	8211/3
Mucinous (colloid) carcinoma	8480/3
Medullary carcinoma	8510/3
Adenoid cystic carcinoma	8200/3
Intraductal papillary carcinoma with invasion	8503/3
Apocrine adenocarcinoma	8401/3
Metaplastic carcinoma	8575/3
Other rare types	
Paget disease (rare without underlying carcinoma, which is usually invasive, but may be DCIS only)	8540/3
II. Invasive only, 2 or more types, no in situ component	
Invasive ductal and lobular	8522/3
Invasive ductal and mucinous (colloid)	8523/3
Invasive ductal and tubular	8523/3
Invasive ductal and cribriform (cribriform also invasive)	8523/3
Invasive lobular and other types (except ductal)	8524/3
III. Invasive, one type, with DCIS or/and LCIS present	
Invasive ductal and DCIS (loses the DCIS)	8500/3
Invasive lobular and DCIS	8522/3
Invasive ductal and LCIS	8522/3
Invasive lobular and LCIS (loses the LCIS)	8520/3
IV. Invasive, 2 or more types, with DCIS or/and LCIS	
Code as in category II; the CIS will be lost	

HISTOLOGY CODES FOR NON-INVASIVE BREAST CANCERS

No invasion present (DCIS and/or LCIS only)

I. Intraductal (ductal carcinoma in situ, DCIS) only	8500/2
II. Intraductal, with one subtype specified	
DCIS papillary (intraductal papillary)	8503/2
DCIS micropapillary or clinging	8507/2
DCIS cribriform	8201/2
DCIS solid	8230/2
DCIS comedo	8501/2
III. Intraductal, with two or more subtypes specified	8523/2
IV. Intralobular (lobular carcinoma in situ, LCIS)	8520/2
V. Both DCIS and LCIS (any DCIS subtypes will be lost)	8522/2

Examples of Complex Breast Diagnoses (coded, with comments)

Assume these examples are single primaries.

8401/3 Core needle breast bx: PD infiltrating ductal carcinoma with aprocrine subtype of ductal ca.
Code the stated subtype of the invasive component.

8500/3 FNA L breast mass, UIQ: Atypical hyperplasia with clusters suspicious for carcinoma.
Needle localization (L breast, UOQ) followed by exc bx: Scirrhous ductal carcinoma and DCIS (comedo pattern); TS = 1.8 x 2.0 x 2.0 cm; extensive cribriforming noted. Margins of resection are clean.
Code the invasive component. "Scirrhous" is an adjective meaning "hard" Although it has a code in ICD-O-3, ductal carcinoma is the more precise term. According to our medical advisor, ignore "scirrhous" when it is used in combination with another histologic descriptor. If the term is "scirrhous carcinoma," code as 8141/3.

8507/3 Infiltrating ductal ca; focal micropapillary invasive pattern and intralymphatic tumor are additional features.
Use the "micropapillary invasive" information to code the more specific term.

8520/3 Infiltrating lobular ca, pleomorphic variant, measuring 5.4 cm.
A pleomorphic variant (subtype) of lobular carcinoma is not the same as pleomorphic carcinoma. Code as lobular carcinoma, NOS.

8522/2 Right breast lumpectomy specimen: Extensive in situ carcinoma with mixed ductal and lobular features and the following characteristics: 1) Two foci suspicious but not definitive for invasion. 2) Solid and cribriform histologic patterns.
Use the guidelines in order. Code the ductal and lobular combination. For coding purposes, any ductal carcinoma subtype should be treated as ductal carcinoma when seen in combination with lobular carcinoma or LCIS.

8522/2 Excision bx right breast: Ductal carcinoma in situ with the following characteristics:
1) cribriform and solid subtype. 2) lobular carcinoma in situ.
Use the guidelines in order. Code the ductal and lobular combination.

8522/2 Left breast core needle bx: ductal carcinoma in situ with the following features:
1) Histologic type: cribriform and solid.
Excisional bx:
1) Lobular carcinoma in situ.
2) Rare microscopic foci of ductal carcinoma in situ with the following features:
a) Histologic type: cribriform.
3) Microcalcifications associated with DCIS and LCIS.
Use the guidelines in order. Code the ductal and lobular combination.

8522/2 Stereotactic breast bx: DCIS with the following features:
Pattern: cribriform and solid.
Excision bx: residual ductal carcinoma in situ with the following features:
Histologic type: Solid and cribriform types.
Medial margin: Rare foci reaching minimal criteria for lobular carcinoma in situ. Negative for invasive ca.
Code as ductal and lobular.

Examples of Complex Breast Diagnoses (coded, with comments), continued

8522/3 Infiltrating duct ca with focal lobular features and focal mucinous features. There is cribriform DCIS with focal comedonecrosis adajacent to the infiltrating component.
Use a combination code for the invasive component. Use the first guideline and code the lobular and ductal combination.

8522/3 Right breast excisional biopsy: infiltrating ductal carcinoma with areas of metaplastic carcinoma with associated DCIS, cribriform histologic type and multiple foci of lobular carcinoma in situ.
Code the combination of invasive ductal and lobular in situ. "With areas of" does not constitute a majority of tumor.

8522/3 Left breast mass excision:
1) Infiltrating carcinoma with the following features:
Histologic type: infiltrating ductal carcinoma of apocrine type.
2) Ductal carcinoma in situ with the following features:
1) Histologic type: Apocrine cell type with papillary and solid architecture.
2) Scattered foci of lobular carcinoma in situ.
Use the combination of ductal and lobular.

8522/3 Ductal and papillary carcinoma with separate foci of lobular ca
Code ductal and lobular combination.

8522/3 Ductal ca, mucinous type, and LCIS.
Use the guidelines in order. Use the combination code of ductal and lobular.

8523/3 Mammogun bxs, R breast, 6 specimens:
Specimen #1, UIQ: Ductal carcinoma, in situ, cribriforming type, BR Score 3
Specimen #2, UOQ: NED
Specimen #3, LIQ: Infiltrating papillary ductal carcinoma, well differentiated
Specimen #4, LOQ: NED
Specimen #5: Central breast: NED
Specimen #6: Nipple complex: NED, flaky nipple observation on physical examination is negative for Paget's disease.
R MRM w/R axill LN dissect: Ductal carcinoma, in situ and infiltrating, cribriform and papillary features observed; BR Score 3 to 4. 16 of 23 R axillary LNs with papillary ductal carcinoma present.
Use a combination code to include the cribriform and papillary features.

8523/2 Exc bx, R breast, UOQ: DCIS, cribriform (comedocarcinoma) and micropapillary, nuclear gr. 3.
Codes as multiple subtypes of DCIS.

8523/2 Stereotactic bx left breast: cribriform ductal carcinoma in situ.
Excisional bx: residual ductal carcinoma in situ, solid type.
Use information from both procedures. Code as multiple subtypes of DCIS.

OTHER COMPLEX MORPHOLOGIC CODES
REVISED 6/17/2002

8255/3 Adenocarcinoma with mixed subtypes
Adenocarcinoma combined with other types of carcinoma

8323/3 Mixed cell adenocarcinoma

THE PROBLEMS
- Terms are not site-specific
- The usual key words we look for can be used for both diagnoses
- Only a pathologist would know the subtle difference between them

UNTIL WE GET FURTHER GUIDANCE ON THESE TWO HISTOLOGIES...

☞ Code mixed cell GYN carcinomas and mixed pancreatic islet cell carcinomas (very rare) to 8323.

☞ Code mixed tumors of all other sites to 8255 unless there is a better complex code available elsewhere.

GYN Cancers of Mixed Cell Types
- Example: Mixed cell adenocarcinoma of ovary can be any combination of
  - 8441 Serous adenocarcinoma
  - 8480 Mucinous adenocarcinoma
  - 8380 Endometrioid adenocarcinoma
  - 8070 Squamous cell carcinoma
  - 9000 Brenner tumor
  - » If more than one mentioned in path report, code to 8323/3 Mixed cell adenocarcinoma

Renal Cell Carcinoma Subtypes

Renal cell carcinoma (NOS, including hypernephroma [obs])	8312/3
Clear cell	8310/3
Papillary (also called chromophil)	8260/3
Chromophobe	8317/3
Sarcomatoid (spindle cell)	8318/3
Granular cell	8320/3
Collecting duct carcinoma	8319/3
Renal oncocytoma	8290/0
Cyst-associated renal cell carcinoma	8316/3

» If more than one mentioned in path report, code to 8255/3 Adenocarcinoma with mixed subtypes

EXAMPLES OF COMPLEX HISTOLOGIES

8255/3 Sigmoid: adenocarcinoma with focal mucinous and clear cell differentiation

8255/3 Renal cell ca, mixed clear cell and chromophobe

8255/3 Renal cell ca with mixed granular cell, clear cell, and collecting duct differentiation

8255/3 Renal cell ca, mixed granular cell and clear cell

8255/3 Lung: adenocarcinoma, mixed acinar and papillary type

8045/3 Lung: mixed carcinoma with poorly differentiated and small cell neuroendocrine carcinoma

8323/3 Endometrium: adenocarcinoma with clear cell, papillary and squamous differentiation

8323/3 Pancreas: mixed alpha cell and beta cell carcinomas

8045/3 COMBINED SMALL CELL AND NON-SMALL CELL CARCINOMA

For single tumors, code 8045/3 should be used for combinations or mixtures of small cell (oat cell) carcinoma and any other type of carcinoma (sometimes referred to as "non-small cell" carcinomas). Combinations containing small cell carcinoma and carcinoids, lymphomas, and sarcomas of the lung cannot be coded as 8045/3. For analysis purposes, 8045/3 is included with small cell carcinomas. There are several synonyms and other names for small cell carcinoma, and many different types of carcinomas and adenocarcinomas other than small cell that may be seen in combination with small cell carcinoma in a single tumor.

See Appendix 1 for a list of terms that mean small cell and a list of 'other than small cell' terms that should be coded to 8045/3 when combined with small cell carcinoma and diagnosed in a single tumor.

MIXED GERM CELL TUMORS

- 9081 Mixed embryonal carcinoma and teratoma
- 9085 Mixed germ cell
  - *usually seminoma and something else*
- 9101 Choriocarcinoma with other germ cell elements

- 9065 Germ cell tumor, nonseminomatous

CHOOSING A CODE FOR A MIXED GERM CELL TUMOR

- Identify the histologies and note which ones are present.

- Common germ cell tumors in order of prognosis
  Non-seminoma (9070-9084, 9100)
    Choriocarcinoma 9100
    Yolk sac tumor 9071
    Embryonal cell 9070
    Teratoma 9080
  Seminoma (9061-9064)

- If one of the cell types is
    choriocarcinoma, use 9101
    embryonal cell, check 9081
    teratoma, check 9081
    seminoma and the other(s) non-seminoma, use 9085

- If NONE of the germ cell types is seminoma, use 9065

CODING TO THE HIGHER MORPHOLOGY CODE

When a complex morphology code is not available and there is no NOS-specific combination and there is no clear majority of one cell type...

- **Code the numerically higher ICD-O-3 code.**

☞ Use the higher morphology code when

- the mixed tumor is glandular (adeno)carcinoma and something else (epithelial carcinoma, sarcoma, melanoma, etc.) and there is no combination code

  Examples: Mixed transitional cell carcinoma and squamous cell carcinoma. *Code to higher code, 8120/3.*
  Poorly-differentiated carcinoma with squamous and neuroendocrine differentiation. *Code to higher code, 8246/3.*
  Oral mucosa: carcinoma with trabecular and acinar pattern. *Code to higher code, 8550/3.*

USING COMPLEX MORPHOLOGY CODES--SUMMARY

- Distinguish between 'subtype of generic term' and multiple cell types in same lesion
- Apply the coding rules in order.
- Understand that some combination codes represent categories, not specific cell types or combinations
- Not all combinations are listed in index
- Use the index AND numeric list
- When in doubt, ask your pathologist or central registry
- Check the pathology 'blue books' if available
- It's OK to change the behavior code
- Document, document, document your choice of codes

ICD-O-3 Combined and Mixed Histology Codes

Not included: commonly recognized combined histologies such as adenocarcinofibroma, carcinosarcoma, fibrohistiocytoma, or atypical teratoid/rhabdoid tumor.

Histologies that are not annotated are most likely simple combinations of two cell types that commonly occur together.

8045/3 Combined small cell carcinoma *(see also Appendix 1)*
Mixed small cell carcinoma
Combined small cell-large cell carcinoma
Combined small cell-adenocarcinoma
Combined small cell-squamous cell carcinoma

8094/3 Basosquamous carcinoma (C44._)
Mixed basal-squamous cell carcinoma C44._)

8154/3 Mixed islet cell and exocrine adenocarcinoma (C25._)
Mixed acinar-endocrine carcinoma (C25._)
Mixed ductal-endocrine carcinoma (C25._)

8180/3 Combined hepatocellular carcinoma and cholangiocarcinoma (C22.0)
Mixed hepatocellular and bile duct carcinoma (C22.0)
Hepatocholangiocarcinoma (C22.0)

8244/3 Composite carcinoid
Combined carcinoid and adenocarcinoma
Mixed carcinoid-adenocarcinoma

8254/3 Bronchiolo-alveolar carcinoma, mixed mucinous and non-mucinous (C34._)
Bronchiolo-alveolar carcinoma, Clara cell and goblet cell type (C34._)
Bronchiolo-alveolar carcinoma, type II pneumocyte and goblet cell type (C34._)
Bronchiolo-alveolar carcinoma, indeterminate type (C34._)

8255/3 Adenocarcinoma with mixed subtypes
Adenocarcinoma combined with other types of carcinoma

8281/3 Mixed acidophil-basophil carcinoma (C75.1)

8323/3 Mixed cell adenocarcinoma *predominantly GYN tumor containing two or more of the following: serous, mucinous, endometrioid, clear cell, transitional cell (Brenner), or squamous cell tumor elements*

8346/3 Mixed medullary-follicular carcinoma (C73.9)

8347/3 Mixed medullary-papillary carcinoma (C73.9)

8522/3 Infiltrating duct and lobular carcinoma (C50._)
Lobular and ductal carcinoma (C50._)
Infiltrating duct and lobular carcinoma in situ (C50._)
Intraductal and lobular carcinoma (C50._)
Infiltrating lobular carcinoma and ductal carcinoma in situ (C50._)

8523/3 Infiltrating duct mixed with other types of carcinoma (C50._)
Infiltrating duct and cribriform carcinoma (C50._)
Infiltrating duct and mucinous carcinoma (C50._)
Infiltrating duct and tubular carcinoma (C50._)
Infiltrating duct and colloid carcinoma (C50._)

8524/3 Infiltrating lobular mixed with other types of carcinoma (C50._)

8560/3 Adenosquamous carcinoma
Mixed adenocarcinoma and squamous cell carcinoma
Mixed adenocarcinoma and epidermoid carcinoma

8582/3 Thymoma, type AB, malignant (C37.9)
Thymoma, mixed type, malignant (C37.9)

8770/3 Mixed epithelioid and spindle cell melanoma

8855/3 Mixed liposarcoma

8902/3 Mixed type rhabdomyosarcoma
Mixed embryonal rhabdomyosarcoma and alveolar rhabdomyosarcoma

8940/3 Mixed tumor, malignant, NOS *unique tumor, not combined different cell types*
Mixed tumor, salivary gland type, malignant (C07._, C08._)
Malignant chondroid syringoma (C44._)

8950/3 Mullerian mixed tumor (C54._) *very similar to 8951*

8951/3 Mesodermal mixed tumor *unique tumor similar to 8950, may also be called carcinosarcoma*

8990/3 Mesenchymoma, malignant *two or more distinct mesenchymal lines*
Mixed mesenchymal sarcoma

9081/3 Teratocarcinoma
Mixed embryonal carcinoma and teratoma

9085/3 Mixed germ cell tumor *two or more of the following: seminoma, embryonal carcinoma, yolk sac tumor, polyembryoma.*
Mixed teratoma and seminoma

9101/3 Choriocarcinoma combined with other germ cell elements
Choriocarcinoma combined with teratoma
Choriocarcinoma combined with embryonal carcinoma

9362/3 Pineoblastoma (C75.3)
Mixed pineal tumor (C75.3) *mature and immature forms of malignant pineal cells*
Mixed pineocytoma-pineoblastoma (C75.3)
Pineal parenchymal tumor of intermediate differentiation (C75.3)
Transitional pineal tumor (C75.3)

9382/3 Mixed glioma (C71._) *two or more neoplastic components from different macroglial lineages: astrocytic, oligodendroglial, and/or ependymal*
Oligoastrocytoma (C71._)
Anaplastic oligoastrocytoma (C71._)

9596/3 Composite Hodgkin and non-Hodgkin lymphoma

9652/3 Hodgkin lymphoma, mixed cellularity, NOS
(background behind malignant cells is mixed, associated with HIV disease)
Classical Hodgkin lymphoma, mixed cellularity, NOS

9665/3 Hodgkin lymphoma, nodular sclerosis, grade 1
Classical Hodgkin lymphoma, nodular sclerosis, grade 1
Hodgkin disease, nodular sclerosis, lymphocyte predominance
Hodgkin disease, nodular sclerosis, mixed cellularity
(background behind malignant cells is mixed)

9675/3 Malignant lymphoma, mixed small and large cell, diffuse [obs] *(see also M-9690/3)*
(mix is size/appearance of malignant cells, not different cells)
Malignant lymphoma, mixed lymphocytic-histiocytic, diffuse [obs]
Malignant lymphoma, mixed cell type, diffuse [obs]
Malignant lymphoma, centroblastic-centrocytic, NOS [obs]
Malignant lymphoma, centroblastic-centrocytic, diffuse [obs]

9691/3 Follicular lymphoma, grade 2 *mix is size/appearance of malignant cells, not different cells*
Malignant lymphoma, mixed small cleaved and large cell, follicular [obs]
Malignant lymphoma, mixed lymphocytic-histiocytic, nodular [obs]
Malignant lymphoma, mixed cell type, follicular [obs]
Malignant lymphoma, mixed cell type, nodular [obs]

9805/3 Acute biphenotypic leukemia *morphologic and/or immunophenotypic characteristics of both myeloid and lymphoid cells or both B and T lineages*
Acute mixed lineage leukemia
Acute bilineal leukemia

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8045/3 Combined Small Cell Carcinoma

For single tumors, code 8045/3 should be used for combinations or mixtures of small cell (oat cell) carcinoma and ANY other carcinoma (sometimes referred to as “non-small cell” carcinomas). Moreover, the related term “combined small cell-adenocarcinoma” includes all types of adenocarcinoma. Combinations with carcinoids, lymphomas and sarcomas of the lung cannot be included in 8045/3. For analysis purposes, 8045/3 is included with small cell carcinomas.

Examples: Small cell and bronchioloalveolar carcinoma
Oat cell and adenocarcinoma
Small cell neuroendocrine and squamous carcinoma
Round cell and large cell carcinoma

A single tumor diagnosis that includes a term from the first column plus a term from the second column should be coded to 8045/3.

Terms that mean "Small Cell"

Limited to ICD-O-3 codes 8041, 8042, 8043, 8044
Oat cell carcinoma
Reserve cell carcinoma
Round cell carcinoma
Small cell carcinoma
Small cell carcinoma, fusiform cell
Small cell carcinoma, intermediate cell
Small cell neuroendocrine carcinoma

Terms that mean other than "Small Cell"
(most common types of non-small cell lung cancers)
Adenocarcinoma *(partial list)*
- NOS 8140
- acinar (acinic cell) 8550
- alveolar 8251
- bronchioloalveolar 8250, 8252-8254
- clear cell 8310
- mucinous (colloid) 8480
- papillary 8260
- "scar" carcinoma 8140
- scirrhous 8141
- solid with mucin formation 8230

Adenosquamous carcinoma 8560
- mixed adenocarcinoma and squamous cell 8560

Giant cell carcinoma 8031
Large cell carcinoma 8012
- neuroendocrine 8013
- with rhabdoid phenotype 8014

Mucoepidermoid carcinoma 8430
Non-small cell carcinoma, NOS 8046
Squamous cell (epidermoid) carcinoma 8070
- acantholytic 8075
- adenoid 8075
- basaloid 8083
- clear cell type 8084
- keratinizing 8071

Terms that mean other than "Small Cell" (Continued)

Squamous cell (epidermoid) carcinoma 8070 (continued)
- large cell keratinizing 8071
- large cell nonkeratinizing 8072
- nonkeratinizing 8072
- pseudoglandular 8075
- sarcomatoid 8074
- small cell nonkeratinizing 8073
- spindle cell 8074

Undifferentiated carcinoma 8020

***Reference**: International Classification of Diseases for Oncology, third edition.* World Health Organization, 2000.

Appendix M

SEER Site-Specific Surgery Codes
Surgery of Primary Codes
Effective for Cases Diagnosed 01/01/2003 and After

Appendix N

Determination of Subsequent Primaries of Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases For Cases Diagnosed before January 1, 2001

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Hodgkin's disease (9650-9667)	Non-Hodgkin's lymphoma (9591-9595, 9670-9686, 9688, 9690-9698, 9702-9717) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700-9701) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740-9741) Immunoproliferative disease, NOS (9760) Waldenstrom's macroglobulinemia (9761) Any leukemia (9800-9941)	Hodgkin's disease[1] (9650-9667) Malignant lymphoma, NOS (9590)

[1]Code to the term with the higher histology code.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Malignant lymphoma, NOS[1] (9590)	Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700, 9701) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) Mast cell tumor (9740, 9741) Acute leukemia, NOS (9801) Non-lymphocytic leukemias (9840-9842, 9860-9910) Myeloid sarcoma (9930) Acute panmyelosis (9931) Acute myelofibrosis (9932) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)	Non-Hodgkin's lymphoma[2] (9590-9595, 9670-9686, 9688, 9690-9698, 9702-9717) Hodgkin's disease[2] (9650-9667) True histiocytic lymphoma (9723) Plasmacytoma[2] or multiple myeloma (9731, 9732) Leukemia, NOS (9800) Chronic leukemia, NOS (9803) Lymphoid or lymphocytic leukemia (9820-9828) Plasma cell leukemia (9830) Lymphosarcoma cell leukemia (9850) Immunoproliferative disease, NOS (9760) Waldentrom's macroglobulinemia (9761)

[1]If the diagnosis includes "can't rule out leukemia" or "consistent with chronic lymphocytic leukemia" and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis, then code only to chronic lymphocytic leukemia (9823/3). If not confirmed as chronic lymphocytic leukemia, then code as the lymphoma.
[2]Presumably this is the correct diagnosis. Code the case to this histology.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Non-Hodgkin's lymphoma[1] (9591-9595, 9670-9686, 9688, 9690-9698, 9711-9717)	Hodgkin's disease (9650-9667) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700, 9701) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) Mast cell tumor (9740-9741) Acute leukemia, NOS (9801) Non-lymphocytic leukemias (9840-9842, 9860-9910) Myeloid sarcoma (9930) Acute panmyelosis (9931) Acute myelofibrosis (9932) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)	Non-Hodgkin's lymphoma[2] (9590-9595, 9670-9686, 9688, 9690-9698, 9702-9717) Plasmacytoma[3] or multiple myeloma (9731, 9732) True histiocytic lymphoma (9723) Leukemia, NOS (9800) Chronic leukemia, NOS (9803) Lymphoid or lymphocytic leukemia (9820-9828) Plasma cell leukemia (9830) Lymphosarcoma cell leukemia (9850) Waldenstrom's macroglobulinemia (9761) Immunoproliferative disease NOS (9760)

[1]If the diagnosis includes "can't rule out leukemia" or "consistent with chronic lymphocytic leukemia" and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis, then code only to chronic lymphocytic leukemia (9823/3). If not confirmed as chronic lymphocytic leukemia, then code as the lymphoma.
[2]Code to the term with the higher histology code.
[3]Presumably this is the correct diagnosis. Code the case to this histology.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Burkitt's lymphoma (9687)	Specific non-Hodgkin's lymphoma (9593-9594, 9670-9686, 9688, 9690-9698, 9702-9717) Hodgkin's disease (9650-9667) Mycosis fungoides or Sezary's disease (9700, 9701) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) Plasmacytoma or multiple myeloma (9731, 9732) True histiocytic lymphoma (9723) Mast cell tumor (9740, 9741) Immunoproliferative disease, NOS (9760) Waldenstrom's macroglobulinemia (9761) Leukemia, NOS (9800) Acute leukemia, NOS (9801)	Malignant lymphoma, NOS (9590-9591, 9595) Lymphosarcoma (9592) Burkitt's lymphoma (9687) Burkitt's leukemia (9826) Lymphoid or lymphocytic leukemia (9820-9822, 9824-9825, 9827-9828)

(Table continued)

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Burkitt's lymphoma (9687) (cont.)	Chronic leukemia, NOS (9803) Chronic lymphocytic leukemia (9823) Non-lymphocytic leukemias (9840-9842, 9860-9910) Plasma cell leukemia (9830) Lymphosarcoma cell leukemia (9850) Myeloid sarcoma (9930) Acute panmyelosis (9931) Acute myelofibrosis (9932) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)	

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Cutaneous and peripheral T-cell lymphomas (9700-9709)	Specific non-Hodgkin's lymphoma (9593-9594, 9670-9688, 9690-9698, 9711-9717) Hodgkin's disease (9650-9667) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Immunoproliferative disease, NOS (9760) Waldenstrom's macroglobulinemia (9761) Lymphoid or lymphocytic leukemia specified as B-cell (9820-9827) Plasma cell leukemia (9830) Non-lymphocytic leukemia (9840-9842, 9860-9910) Lymphosarcoma cell leukemia (9850)	Malignant lymphoma, NOS (9590-9591, 9595) Lymphosarcoma (9592) Cutaneous and peripheral T-cell lymphomas (9700-9709) Leukemia, NOS (9800) Acute leukemia, NOS (9801) Chronic leukemia, NOS (9803) Lymphoid or lymphocytic leukemia unless specifically identified as B-cell (9820-9828)

(Table continued)

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Cutaneous and peripheral T-cell lymphomas (9700-9709) (cont.)	Myeloid sarcoma (9930) Acute panmyelosis (9931 Acute myelofibrosis (9932) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)	

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a subsequent Primary (only One Primary)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722, 9723)	Specific non-Hodgkin's lymphoma (9592-9594, 9670-9686, 9688, 9690-9698, 9702-9717) Hodgkin's disease (9650-9667) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700, 9701) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Immunoproliferative disease, NOS (9760) Waldenstrom's macroglobulinemia (9761) Leukemia except hairy cell and leukemic reticuloendotheliosis (9800-9932)	Non-Hodgkin's lymphoma, NOS (9590-9591, 9595) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722, 9723) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Plasmacytoma or multiple myeloma (9731, 9732)	Non-Hodgkin's lymphoma except immunoblastic or large-cell lymphoma (9592-9594, 9670, 9672-9677, 9683, 9685-9686, 9688, 9690-9697, 9702-9713, 9715-9717) Hodgkin's disease (9650-9667) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700, 9701) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) True histiocytic lymphoma (9723) Mast cell tumor (9740, 9741) Immunoproliferative disease NOS (9760) Leukemia except plasma cell (9800-9828, 9840-9941)	Malignant lymphoma, NOS (9590, 9591, 9595) Immunoblastic or large cell lymphoma[1] (9671, 9680-9682, 9684, 9698, 9714) Plasmacytoma or multiple myeloma (9731, 9732) Waldenstrom's macroglobulinemia (9761) Plasma cell leukemia (9830)

[1]Occasionally multiple myeloma develops an immunoblastic or large cell lymphoma phase. This is to be considered one primary, multiple myeloma. Consult your medical advisor or pathologist if questions remain.

DETERMINING OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL OR EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Mast cell tumor (9740, 9741)	Non-Hodgkin's lymphoma (9590-9595, 9670-9688, 9690-9698, 9702-9717) Hodgkin's disease (9650-9667) Mycosis fungoides or Sezary's disease (9700, 9701) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Immunoproliferative disease, NOS (9760) Waldenstrom's macroglobulinemia (9761) Lymphoid or lymphocytic leukemia (9820-9828) Chronic lymphocytic leukemia (9823) Plasma cell leukemia (9830)	Mast cell tumor (9740, 9741) Leukemia, NOS (9800) Acute leukemia, NOS (9801) Chronic leukemia, NOS (9803) Monocytic leukemia (9890-9894) Mast cell leukemia (9900)

(Table continued)

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Mast cell tumor (9740, 9741) (cont.)	Non-lymphocytic leukemias (9840-9842, 9860-9880, 9910) Lymphosarcoma cell leukemia (9850) Myeloid sarcoma (9930) Acute panmyelosis (9931) Acute myelofibrosis (9932) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)	

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Immunoproliferative disease, NOS (9760) Waldenstrom's macroglobulinemia (9761)	Non-Hodgkin's lymphoma except immunoblastic or large cell lymphoma (9593-9594, 9673-9677, 9683, 9685-9686, 9688, 9690-9697, 9702-9713, 9715-9717) Hodgkin's disease (9650-9667) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700, 9701) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) True histiocytic lymphoma (9723) Mast cell tumor (9740, 9741) Leukemia except plasma cell (9800-9828, 9840-9941)	Malignant lymphoma, NOS (9590, 9591, 9595) Lymphosarcoma (9592) Immunoblastic or large cell lymphoma (9671, 9680-9682, 9684, 9698, 9714) Malignant lymphoma, lymphocytic (9670, 9672) Plasmacytoma or multiple myeloma (9731, 9732) Immunoproliferative disease, NOS (9760) Waldenstrom's macroglobulinemia (9761) Plasma cell leukemia (9830)

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Leukemia, NOS (9800)	Non-Hodgkin's lymphoma[1] (9590-9595, 9670-9688, 9690-9698, 9702-9717) Hodgkin's disease (9650-9667) Mycosis fungoides (9700) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Immunoproliferative disease, NOS (9760) Waldenstrom's macroglobulinemia (9761)	Any leukemia[2] (9800-9941) Sezary's disease[3] (9701)

[1]If the diagnosis includes "can't rule out leukemia" or "consistent with chronic lymphocytic leukemia" and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis, then code only to chronic lymphocytic leukemia (9823/3). If not confirmed as chronic lymphocytic leukemia, then code as the lymphoma.

[2]Note: Leukemia, NOS (9800) should be upgraded to a more specific leukemic diagnosis (higher number) when it is found but not considered a second primary.

[3]Presumably this is the correct diagnosis. Code the case to this histology.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Acute leukemia, NOS (9801)	Non-Hodgkin's lymphoma (9590-9595, 9670-9688, 9690-9698, 9702-9717) Hodgkin's disease (9650-9667) Mycosis fungoides (9700) Malignant histiocytosis Letterer-Siwe's disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Immunoproliferative disease, NOS (9760) Waldenstrom's macroglobulinemia (9761)	Any leukemia[1] (9800-9941) Sezary's disease[2] (9701)

[1]Note: Acute leukemia, NOS (9801) should be upgraded to a more specific type of acute leukemia (higher number) when it is found, but not considered a second primary.

[2]Presumably this is the correct diagnosis. Code the case to this histology.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Chronic leukemia, NOS (9803)	Hodgkin's disease (9650-9667) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) Mast cell tumor (9740, 9741)	Non-Hodgkin's lymphoma[1] (9590-9595, 9670-9686, 9688, 9690-9698, 9702-9717) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700, 9701) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Immunoproliferative disease, NOS (9760) Waldenstrom's macroglobulinemia (9761) Any leukemia[2] (9800-9941)

[1]If the diagnosis includes "can't rule out leukemia" or "consistent with chronic lymphocytic leukemia" and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis, then code only to chronic lymphocytic leukemia (9823/3). If not confirmed as chronic lymphocytic leukemia, then code as the lymphoma.

[2]Note: Chronic leukemia, NOS (9803) should be upgraded to a more specific type of chronic leukemia (higher number) when it is found, but not considered a second primary.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Lymphocytic leukemia (9820-9828)	Hodgkin's disease (9650-9667) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Immunoproliferative disease, NOS (9760) Waldenstrom's macroglobulinemia (9761) Non-lymphocytic leukemias[1] (9840-9842, 9860-9910) Myeloid sarcoma[1] (9930)	Non-Hodgkin's lymphoma[2] (9592-9595, 9670-9688, 9690-9698, 9702-9717) Malignant lymphoma, NOS[2] (9590-9591) Mycosis fungoides or Sezary's disease[3] (9700, 9701) True histiocytic lymphoma (9723) Leukemia, NOS (9800) Acute leukemia, NOS (9801) Chronic leukemia, NOS (9803) Lymphocytic leukemia[3] (9820-9828)

(Table continued)

[1]If any of the diagnoses are made within 4 months of lymphocytic leukemia, NOS (9820) or acute lymphocytic leukemia (9821), one of the two diagnoses probably is wrong. The case should be reviewed.

[2]If the diagnosis includes "can't rule out leukemia" or "consistent with chronic lymphocytic leukemia" and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis, then code only to chronic lymphocytic leukemia (9823). If not confirmed as chronic lymphocytic leukemia, then code as the lymphoma.

[3]Note: Lymphocytic leukemia, NOS (9820) should be upgraded to a more specific diagnosis that is not considered a second primary.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Lymphocytic leukemia (9820-9828) (cont.)	Acute panmyelosis[2] (9931) Acute myelofibrosis[2] (9932)	Plasma cell leukemia[1] (9830) Lymphosarcoma cell leukemia[1] (9850) Hairy cell leukemia[1] (9940) Leukemic reticuloendotheliosis[1] (9941)

[1]Note: Lymphocytic leukemia, NOS (9820) should be upgraded to a more specific diagnosis that is not considered a second primary.

[2]If any of these diagnoses are made within 4 months of lymphocytic leukemia, NOS (9820) or acute lymphocytic leukemia (9821), one of the two diagnoses probably is wrong. The case should be reviewed.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Plasma cell leukemia (9830)	Non-Hodgkin's lymphoma (9590-9595, 9670-9686, 9688, 9690-9698, 9702-9717) Hodgkin's disease (9650-9667) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700, 9701) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) True histiocytic lymphoma (9723) Mast cell tumor (9740, 9741) Non-lymphocytic leukemia (9840-9842, 9860-9910) Myeloid sarcoma (9930) Acute panmyelosis (9931) Acute myelofibrosis (9932)	Plasmacytoma or multiple myeloma (9731, 9732) Immunoproliferative disease, NOS (9760) Waldenstrom's macroglobulinemia (9761) Leukemia, NOS (9800) Acute leukemia, NOS (9801) Chronic leukemia, NOS (9803) Lymphocytic leukemia (9820-9828) Plasma cell leukemia (9830) Lymphosarcoma cell leukemia (9850) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Lymphosarcoma cell leukemia (9850)	Hodgkin's disease (9650-9667) Mycosis fungoides or Sezary's disease (9700, 9701) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) Mast cell tumor (9740, 9741) Non-lymphocytic leukemia (9840-9842, 9860-9941)	Non-Hodgkin's lymphoma (9590-9595, 9670-9688, 9690-9698, 9702-9717) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731-9732) Immunoproliferative disease, NOS (9760) Waldenstrom's macroglobulinemia (9761) Leukemia, NOS (9800) Acute leukemia, NOS (9801) Chronic leukemia, NOS (9803) Lymphocytic leukemia (9820-9828) Plasma cell leukemia (9830) Lymphosarcoma cell leukemia (9850)

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Non-lymphocytic leukemias (9840-9842, 9860-9894, 9910-9932)	Non-Hodgkin's lymphoma (9590-9595, 9670-9686, 9688, 9690-9698, 9702-9717) Hodgkin's disease (9650-9667) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700, 9701) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Immunoproliferative disease, NOS (9760) Waldenstrom's macroglobulinemia (9761) Lymphocytic leukemia (9820-9828) Plasma cell leukemia (9830)	Leukemia, NOS (9800) Acute leukemia, NOS (9801) Chronic leukemia, NOS (9803) Non-lymphocytic leukemias[1] (9840-9842, 9860-9894, 9910-9932)

(Table continued)

[1]Code to the term with the higher histology code.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Non-lymphocytic leukemias (9840-9842, 9860-9894, 9910-9932) (cont.)	Lymphosarcoma cell leukemia (9850) Mast cell leukemia (9900) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)	

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Mast cell leukemia (9900)	Non-Hodgkin's lymphoma (9590-9595, 9670-9686, 9688, 9690-9698, 9702-9717) Hodgkin's disease (9650-9667) Burkitt's lymphoma (9687) Mycosis fungoides of Sezary's disease (9700, 9701) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Immunoproliferative disease, NOS (9760) Waldenstrom's macroglobulinemia (9761) Any other leukemia (9820-9894, 9910-9941)	Mast cell tumor (9740, 9741) Leukemia, NOS (9800) Acute leukemia, NOS (9801) Chronic leukemia, NOS (9803) Mast cell leukemia (9900)

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES FOR CASES DIAGNOSED BEFORE JANUARY 1. 2001		
First Primary	Presumably a Second or Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Hairy cell leukemia or leukemic reticuloendotheliosis (9940, 9941)	Non-Hodgkin's lymphoma (9590-9595, 9670-9686, 9688, 9690-9698, 9702-9717) Hodgkin's disease (9650-9667) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700, 9701) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Immunoproliferative disease, NOS (9760) Waldenstrom's macroglobulinemia (9761) Any non-lymphocytic leukemia (9800-9804, 9830-9932) Lymphocytic leukemia (9821-9828)	Malignant histiocytosis or Letterer-Siwe's (9720, 9722) Lymphocytic leukemia, NOS (9820) Hairy cell leukemia or leukemic reticuloendotheliosis (9940, 9941)